A TREATMENT IMPROVEMENT PROTOCOL

Behavioral Health Services for People Who Are Homeless

TIP 55

Substance Abuse and Mental Health Services Administration
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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Disclaimer

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Contents

Consensus Panel v
What Is a TIP? vii
Foreword ix
How This TIP Is Organized xi

PART 1: A PRACTICAL GUIDE FOR THE PROVISION OF BEHAVIORAL HEALTH SERVICES 1

Part 1, Chapter 1 3
Introduction 3
Homelessness in America 11
Homelessness and Behavioral Health Services 17
Stages of Change, Recovery, and Rehabilitation 25
Clinical Interventions and Strategies for Serving People Who Are Homeless 32
Special Issues in Service Delivery 44
Community Housing Services for People Who Are Homeless 46
You Can Do It 54

Part 1, Chapter 2 55
Introduction 55
Vignette 1—Juan 57
Vignette 2—Francis 72
Vignette 3—Roxanne 83
Vignette 4—Troy 100
Vignette 5—René 113
Vignette 6—Mikki 129
Vignette 7—Sammy 139

PART 2: AN IMPLEMENTATION GUIDE FOR BEHAVIORAL HEALTH PROGRAM ADMINISTRATORS 149

Part 2, Chapter 1 151
Introduction 151
Developing Services for Clients Who Are Homeless 152
The Housing First Approach 153

Challenges in Adapting Programs To Address the Needs of People Who Are Homeless 155
Modifying Behavioral Health Services To Meet the Needs of Clients Who Are Homeless . . 157
Interacting With Community Resources To Build a Continuum of Care. 162
Collaborative Partnerships 162
Internet Resources 166
Integrating Behavioral Health Services With a Community System of Homelessness Services. 166
Building Linkages Among Services 173
Funding Community Homelessness Services. 175

Part 2, Chapter 2. 179
Introduction 179
Organizational Approaches to Programming for Homelessness Services 179
Sample Policies and Procedures 183
Sample Forms 190

Appendices
Appendix A—Bibliography **199**
Appendix B—Advisory Meeting Panel 213
Appendix C—Stakeholders Meeting Participants 215
Appendix D—Field Reviewers. 219
Appendix E—Acknowledgments. 221

Index 223

Exhibits
Exhibit 1-1: Types of Prevention as Described by the Institute of Medicine 8
Exhibit 1-2: Agencies That Provide Substance Abuse Prevention and Mental Health Promotion Services. 10
Exhibit 1-3: Stages of Change 25
Exhibit 1-4: Behavioral Health Service Provider Roles and Best Practices According to Stage of Recovery 27
Exhibit 1-5: Substance Use and Mental Disorder Recovery Processes 28
Exhibit 1-6: Promising and Evidence-Based Practices by Rehabilitation Stage 40
Exhibit 1-7: Housing Designations and Readiness to Change Substance Use 52
Exhibit 2-1: Range of Estimated Service Costs per Day by Setting 153
Exhibit 2-2: Key Components for Bottom-Up Modification 158
Exhibit 2-3: Integrated System of Homelessness Services 163
Exhibit 2-4: How To Develop Partnerships 165
Exhibit 2-5: How To Document Partnerships 165

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts in various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://kap.samhsa.gov.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

Foreword

The Treatment Improvement Protocol (TIP) series fulfills the Substance Abuse and Mental Health Services Administration's (SAMHSA's) mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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How This TIP Is Organized

This Treatment Improvement Protocol (TIP) is divided into three parts:

- Part 1: *A Practical Guide for the Provision of Behavioral Health Services*
- Part 2: *An Implementation Guide for Behavioral Health Program Administrators*
- Part 3: *A Review of the Literature*

Part 1 is for behavioral health service providers and consists of two chapters. Chapter 1 illustrates typical problems and issues that arise in behavioral health counseling with people who have experienced or currently are experiencing homelessness. It covers:

- Approaches that address the counselor's setting, role, and responsibilities.
- Screening/assessment, client-centered treatment planning, treatment processes, and continuing care.

Part 1, Chapter 2, presents seven vignettes; each describes the setting in which the counselor is providing services, step-by-step instructions for specific counseling techniques, and master clinician comments. A decision tree is also included in the Francis vignette to help counselors manage key points of therapy. The techniques can be applied to and adapted for other settings. Vignettes are based on role-played interactions staged by consensus panelists.

Part 2 is for program administrators and consists of two chapters addressing the following topics about servicing people who are homeless:

- Collaboration with other service providers to provide comprehensive services
- Service modifications to meet the individual needs of clients
- Providing training and staffing programs that serve people who are homeless
- Providing outreach and engagement, intensive care, and ongoing rehabilitation services
- Resources for implementation of best practices, including sample policies and procedures

Part 3 is a literature review on the topic of homelessness and behavioral health services and is intended for use by clinical supervisors, interested providers, and administrators. Part 3 has three sections: an analysis of the literature, links to select abstracts of the references most central to the topic, and a general bibliography of the available literature. To facilitate ongoing updates (performed periodically for up to 3 years from first publication), the literature review is only available online at the Knowledge Application Program Web site (http://kap.samhsa.gov).

Terminology

Substance abuse: Throughout the TIP, the term "substance abuse" has been used to refer to both substance abuse and substance dependence (as defined by the *Diagnostic and Statistical Manual of Mental Disorders,* 4th Edition, Text Revision [DSM-IV-TR] [American Psychiatric Association, 2000]). This term was chosen partly because substance abuse treatment professionals commonly use the term "substance abuse" to describe any excessive use of addictive substances. In this TIP, the term refers to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine what possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders described by DSM-IV-TR.

Behavioral health: Throughout the TIP, the term "behavioral health" is used. Behavioral health refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illness and substance use disorders, which are often chronic in nature but from which people can and do recover. The term is also used in this TIP to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use and related problems, treatments and services for mental and substance use disorders, and recovery support. Because behavioral health conditions, taken together, are the leading causes of disability burden in North America, efforts to improve their prevention and treatment will benefit society as a whole. Efforts to reduce the impact of mental and substance use disorders on communities in the United States, such as those described in this TIP, will help achieve nationwide improvements in health.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Major dimensions that support a life in recovery, as defined by the Substance Abuse and Mental Health Services Administration, include:

- ***Health:*** overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way.
- ***Home:*** a stable and safe place to live.
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- ***Community:*** relationships and social networks that provide support, friendship, love, and hope.

Part 1: A Practical Guide for the Provision of Behavioral Health Services

Part 1, Chapter 1

IN THIS CHAPTER

- Introduction
- Homelessness in America
- Homelessness and Behavioral Health Services
- Stages of Change, Recovery, and Rehabilitation
- Clinical Interventions and Strategies for Serving People Who Are Homeless
- Special Issues in Service Delivery
- Community Housing Services for People Who Are Homeless
- You Can Do It

Introduction

This TIP Is for You, the Behavioral Health Service Provider

This Treatment Improvement Protocol (TIP) is for you, the behavioral health service provider or program administrator who wants to work more effectively with people who are homeless or at risk of homelessness and who need, or are currently in, substance abuse or mental health treatment. The TIP addresses treatment and prevention issues. Some aspects of the TIP will be of primary interest to counselors across settings, whereas others will be of primary interest to prevention professionals or providers in primary care settings. However, the approach advocated by the TIP is *integrated* and is aimed at providing services to the whole person to improve quality of life in all relevant domains.

The information in this TIP can be useful to you if you wish to:

- Be a more effective clinician for people facing potential or actual homelessness.
- Recognize and address homelessness as a special dynamic that affects your clients.
- Help prevent potential crises that result from becoming homeless.
- Provide preventive services for individuals and families who are homeless, especially as they relate to emergent substance abuse or mental disorders.
- Be more aware of the effects of psychological trauma and co-occurring disorders (CODs) among people who are homeless.
- Provide integrated, more effective services to people who are homeless.
- Understand and know how to utilize resources for homelessness (e.g., permanent supportive housing [PSH]) in your community.

- Understand the significance of cultural competence in your work with people who are homeless and experience substance use and mental disorders.
- Influence the understanding of others in your community regarding the interrelationship of homelessness, substance abuse, and mental illness.

Behavioral health service providers work today in a variety of settings: publicly funded treatment programs, primary care organizations, hospitals, criminal justice settings, private practice, the military, schools, the community, and programs specifically for people who are homeless. You will find the information in this TIP useful regardless of the setting in which you work. Although some content may be more relevant to your work than other content, it is important to have an overall view of how homelessness, substance abuse, and mental illness interact to hinder recovery and rehabilitation; how to form a conceptual model to address homelessness in your work; and how to access services available in your community.

This chapter introduces you to homelessness in America. It illustrates how homelessness affects people, why it often occurs in conjunction with other social and health problems, and why it cannot be addressed in isolation. It also provides a brief overview of how communities address homelessness and discusses different types of homelessness and how each interacts with substance use and mental disorders.

In addition, the chapter discusses your role(s) as a provider in working with this population. Some of the topics addressed include:

- The special competencies you will need in your work with people who are homeless.
- Knowledge, skills, and attitudes in working with specialized community resources that can support treatment and prevention for people who are homeless.
- How to build responses for homelessness or the threat of homelessness into individualized service or treatment plans.
- How to adapt services to the changing needs of people who are homeless as their life situations change.
- How to help individuals without permanent housing integrate with other people in behavioral health service settings.
- The types of preventive services people who are homeless may need.
- Provider self-care when working with the problems of homelessness.

The chapter closes with a discussion of how communities can address homelessness and acquaints you with services that may be available in your community for people who are experiencing or who may be at risk for the overwhelming problem of homelessness. Many resources already exist, and it is important for you as a behavioral health service provider to understand and actively interact with existing organizations to provide integrated, continuous, and nonduplicative service to clients who are homeless.

Structure of the TIP

This TIP has three parts:

- Part 1: *A Practical Guide for the Provision of Behavioral Health Services*
- Part 2: *An Implementation Guide for Behavioral Health Program Administrators*
- Part 3: *A Review of the Literature*

Part 1 is for behavioral health service providers and consists of two chapters. In addition to background information, Chapter 1 illustrates common issues that arise in working with people who have experienced, are currently experiencing, or may be at risk for homelessness. It covers:

- Background issues, such as the nature and extent of homelessness among clients in treatment, descriptions of models, and

principles of care that anchor the practical information the TIP presents.
- The service provider's roles, competencies, and self-care.
- Outreach, assessment, treatment planning, the treatment process, and continuing care.
- Preventive services for people who are homeless.

Part 1, Chapter 2, presents a series of vignettes that serve as teaching tools. Treatment vignettes describe the setting in which a worker provides services, step-by-step instructions for specific clinical techniques, and master clinician comments. Vignettes that incorporate prevention interventions describe situations in which a behavioral health service provider assesses prevention needs and either provides services or refers to a community agency. Some vignettes provide decision trees to help behavioral health service providers manage key points of service delivery. Most of the vignettes are based on role-plays conducted by the TIP consensus panelists.

Part 2 is for program administrators and consists of two chapters. Chapter 1 deals with providing programming tailored to the needs of people who are homeless, including:
- Tailoring services to the needs of the population.
- Providing training and staffing to serve people who are homeless.
- Providing outreach and engagement, intensive care, and ongoing rehabilitation services.

Part 2, Chapter 2, contains sample policies and procedures that support effective services and collaboration with other service providers to offer comprehensive services for people who are homeless, along with sample forms and lists of steps for program modification.

Part 3 has three sections: a review of the literature on the prevention and treatment of substance abuse and/or mental illness among individuals who are homeless, links to select abstracts of the references most central to the topic, and a general bibliography of available literature. To facilitate ongoing updates (performed periodically for up to 3 years from first publication), the literature review is only available online at the Knowledge Application Program Web site (http://kap.samhsa.gov).

Topics Addressed in This TIP

This TIP covers a broad range of skills and resources useful in work with people experiencing homelessness or at significant risk for homelessness. For instance, the TIP addresses different types of homelessness: transitional, episodic, and chronic. It provides information on different resources and services for people who lack adequate housing, including emergency, temporary, transitional supportive, and permanent supportive housing resources. It describes a variety of strategies that are instrumental in services to people who are homeless, including outreach, initial screening and evaluation, early intervention and stabilization, coordination with other resources in the community, treatment planning, case management, client retention in treatment and rehabilitation, and relapse prevention and recovery management. It also sensitizes clinicians to the special effects of psychological trauma, both as a precursor and a contributing factor to homelessness and as a secondary outcome of homelessness. The TIP considers the effects of co-occurring disorders as a causative factor of homelessness and the special needs of clients who are homeless and have co-occurring substance use and mental disorders.

The TIP considers stages of homelessness rehabilitation, including outreach and engagement, transition to intensive care, intensive care, transition to ongoing rehabilitation, and

rehabilitation. It covers a variety of evidence-based practices for both prevention and treatment. Part 2 of the TIP considers major funding resources, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Veterans Affairs (VA), and other governmental resources; staffing; and other information of benefit to administrators.

The TIP is comprehensive in scope and provides the detail that counselors, preventionists, and other professional staff need to provide services in a variety of contexts to clients with a variety of needs. The TIP describes intervention methods that can be used in a variety of stages of homelessness rehabilitation and methods for pursuing recovery from mental illness and substance abuse among people and families who are homeless. It addresses the importance of the integration of behavioral health services with other social services and health care. The TIP recognizes the complexity of providing services to clients who are in stressful life situations and may resist or misinterpret the efforts of service providers. Perhaps most importantly, the TIP emphasizes the need for behavioral health systems to address the needs of the whole person, including not only mental health issues and substance use, but housing, safety, physical health, financial, vocational, family, interpersonal, and other life contexts.

Additionally, this TIP considers content from SAMHSA's Strategic Initiatives (SIs), which are delineated in the document entitled *Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014* (SAMHSA, 2011b). The specific SIs addressed include:

- **Prevention of substance abuse and mental illness** (SI #1) by creating safe places for people to live accompanied by mental health and substance abuse screening and supportive treatment.
- Reducing the potential for and effects of violence and **trauma** (SI #2) by providing safe environments and by recognizing trauma symptoms and providing trauma-informed services.
- The provision of homelessness services to **military families** (SI #3) and veterans, which includes recognizing their special needs and the importance of coordinating their care with the VA.
- Utilizing **recovery supports** (SI #4) provided by people in recovery from mental illness and substance abuse in the community to support individuals and families who are homeless.
- Creating **public awareness and support** (SI #8) for people who are homeless and have mental illness and/or substance use disorders.

Did You Know?

- There is no typical profile for persons experiencing homelessness. A person who is homeless may be, for example:
  - Someone who has lost his or her job or experienced mortgage foreclosure and has been evicted along with family members.
  - A loner who sleeps in the park in a sleeping bag.
  - An individual leaving jail or prison who has an untreated drug problem and no place to live.
  - A runaway teen who trades sex for food and drugs.
  - A person in early recovery without enough money to pay the rent.
  - A person with serious mental illness (SMI) who needs long-term permanent supportive housing.

  - A person kicked out of the family home due to problems accompanying substance abuse.
- More than 1 in 10 persons seeking substance abuse or mental health treatment in the public health system in the United States is homeless (SAMHSA, Office of Applied Studies [OAS], 2006).
- Keeping things together while being homeless takes considerable skill and resourcefulness. People who are homeless often have well-developed street skills, resourcefulness, and knowledge of the service system—important strengths that can be built upon in treatment.
- People who are homeless, particularly those with co-occurring mental and substance use disorders, present particular challenges in treatment. All issues must be concurrently addressed for treatment to be effective.
- People with substance use or mental disorders who are homeless are more likely to have immediate life-threatening health conditions and to live in life-threatening situations. The first steps toward healing may be access to medical care and a safe and healthy place to live.
- Trauma is another major co-occurring problem for people who are homeless and have a substance use disorder. One study found that about one fifth of men and one third of women who are chronically homeless and have substance use disorders also have posttraumatic stress disorder (PTSD; Jainchill, Hawke, & Yagelka, 2000).
- Safe housing is a point of entry into treatment for many individuals. When safe housing is combined with services, the client has the opportunity to build strengths to move from the precontemplation stage through the contemplation stage to an active stage of change concerning recovery from mental illness and substance abuse.
- Many individuals in early recovery are only a paycheck away from homelessness.
- People leaving prison or jail with no place to live who have an untreated substance use or mental disorder may lack familial, occupational, and social resources and supports.
- People who have experienced multiple episodes of homelessness or who have been chronically homeless may be especially demoralized and depressed. In addition, in prior contacts with service systems, these individuals may have experienced alienation that will require behavioral health service providers to exercise a full battery of professional engagement and customer service skills.

Why Address Homelessness in Substance Abuse and Mental Health Programs?

Serving people who are homeless in behavioral health agencies is challenging. So, why do it?

- It is crucial. Housing instability is common among people diagnosed with substance use or mental disorders. This instability may take the form of:
  - Risk of eviction and/or estrangement from families.
  - Risk of homelessness after a stay in jail, prison, or residential treatment.
  - An inability to maintain adequate housing over a period of time.
- Housing stability is key for long-term recovery from substance use and mental disorders; providing housing with treatment and other services reduces relapse (Kertesz, Horton, Friedmann, Saitz, & Samet, 2003) and improves outcomes (Milby et al., 2008; Sosin, Bruni, & Reidy, 1995).
- It is good for your organization. Addressing the root causes of crises caused by homelessness results in better client retention,

efficient organizational functioning, and greater program service diversity.
- Participation in your community's continuum of care for homeless assistance services fosters professional relationships, funding opportunities, innovative programming, and access to a broader range of services for the people you are serving.
- It is good for your community. As communities develop plans to end homelessness, increased funding and resources become available to implement programs and coordinate services. Programs are able to target and respond to specific community needs more efficiently and effectively, and some of the problems intensified by homelessness—such as aggressive panhandling—are reduced.

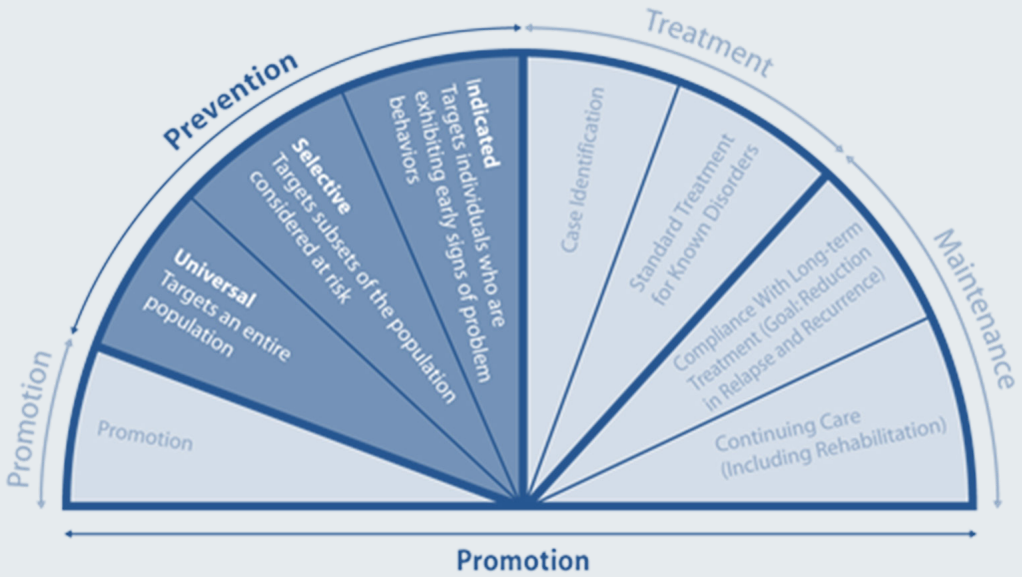
Preventive Services for People Who Are Homeless

People who are homeless are at elevated risk for substance abuse, mental disorders, and various other physical ailments and social problems (e.g., unemployment, poverty, victimization). Preventive services can reduce these risks before problems occur or when early signs of the problem are evident. As shown in Exhibit 1-1, the Institute of Medicine (IOM; 2009) divides substance abuse and mental health services into four broad categories: promotion, prevention, treatment, and maintenance. Prevention services are further divided into:

- Universal prevention services, which target entire populations (i.e., a community, State, or country).
- Selective prevention services, which target subsets of the population considered to be at risk.
- Indicated prevention services, which are delivered to individuals and target people who are exhibiting early signs of problem behaviors.

By definition, universal prevention efforts are not specifically targeted to persons who are homeless because they are part of a larger community, State, or national population.

Exhibit 1-1: Types of Prevention as Described by the Institute of Medicine



Source: IOM, 2009. Adapted with permission.

However, people who are homeless may be the beneficiaries of these prevention efforts (e.g., workplace programs, recreation programs, enforcement efforts to reduce crime, school-based prevention programs for children enrolled in school). Because of their high-risk status, these efforts may be especially important to persons who are homeless or at risk of becoming homeless.

This TIP focuses primarily on selective and indicated prevention, referring to them collectively as "clinical preventive services," as they are often provided in clinical settings (primary care, hospitals, counseling centers, etc.). Clinical preventive services include life skills development, stress and anger management, anticipatory guidance, parenting programs, and screening and early intervention. These programs may be designed to directly prevent substance abuse and/or promote mental health and may strengthen individuals and families and enrich quality of life to build resiliency.

The categories in Exhibit 1-1 are tools for considering prevention initiatives; they aren't hard and fast. In practice, they often blend, and a given initiative may fit into more than one category.

Housing as prevention

Providing housing to people who are homeless can help prevent the exacerbation of substance use and mental disorders or the transition from normal functioning to the first phases of problem development. A number of considerations support this assertion.

Homelessness itself is a risk factor for mental and substance use disorders, given the many life challenges and disruptions that people who are homeless face: for example, stress, loss of social connectivity, increased threats, harm through victimization and exposure, and deterioration of health status. Indeed, these risk factors for adults and youth are one reason this TIP emphasizes the importance of preventive services for people who are homeless.

Effects may be especially acute in children, for whom homelessness may mean a loss of family stability, disruptions in school attendance or performance, and being ostracized by peers. Brokering prevention services in the community can help mitigate the impact of these circumstances (see the "Case Management" section later in this chapter as well as Vignettes 4 and 6 in Part 1, Chapter 2).

Are you a prevention worker in the behavioral health field?

When many professionals think of prevention service providers, mental health and substance abuse workers come to mind. In truth, a broad array of professionals in the community contributes to the treatment and prevention of mental illness and substance abuse. The community agencies and organizations listed in Exhibit 1-2 have a part to play in the prevention of these problems. If your agency or organization is on this list, you are a prevention worker.

Not only does your community benefit when professionals from a wide range of sectors participate in prevention; you may also find your job to be easier as well. People with substance use or mental disorders often present significant treatment challenges in the community agencies and organizations with which they have contact. When substance abuse and mental health issues are prevented or identified early, quality of life improves for everyone.

It is beyond the scope of this TIP to provide an introduction to prevention theory and practice. Instead, it focuses on preventive services for persons who are homeless.

Exhibit 1-2: Agencies That Provide Substance Abuse Prevention and Mental Health Promotion Services

State Governments
Public health authority
Substance abuse authority
Mental health authority
Governor's Highway Traffic Safety Office
Alcohol beverage control
State aging and disability authority
State police
Corrections

County/Local Governments
Public health authority
Substance abuse authority
Mental health authority
Tribal governments
Courts/probation
Local police
Recreation departments
Area agencies on aging

Educational Institutions
K–12 schools
Colleges, universities
Research centers

Healthcare Facilities
Primary care
Specialty care (e.g., mental health/substance abuse, emergency/trauma, obstetrics and gynecology, home health, dentistry)

Nongovernmental Organizations
Community coalitions
Boys/Girls Clubs, Young Men's/Women's Christian Association (YMCA/YWCA), Scouts
Fraternal organizations
Faith-based organizations
Hospitality industry
Housing and homelessness service organizations

Media Outlets
Print
Electronic
Billboards, bus placards, etc.

Recommendations of the Consensus Panel

You are a behavioral health professional working with people who are homeless or at risk for homelessness, but most likely, your background does not include detailed training in addressing this aspect of their lives. This TIP is designed to fill that gap and increase your understanding of how homelessness affects a person's ability to engage in treatment or benefit from prevention. In particular, the consensus panel recommends the following:

- Housing access is the bulwark of recovery for a person who is homeless and has a substance use disorder and/or a mental illness. Various housing models can be effective in addressing homelessness and substance abuse or mental illness. You must be active in identifying housing resources as you assess and work with abstinence readiness in your clients.
- Solving homelessness is more than just having a safe place to live. Homelessness typically presents along with multiple, complex other problems: substance abuse, mental health issues, medical problems, legal/criminal justice issues, social challenges, and so forth. You must be able to prioritize these factors when creating a person-centered treatment or prevention plan and know how to access appropriate supervision concerning these complexities.
- People who experience homelessness can be particularly demoralized, needing active and often persistent engagement; be flexible in engaging them, especially in earlier stages of work.
- Income stability through access to Federal or local income benefits is a critical ingredient in helping a person who is homeless

reintegrate into the social mainstream. Clinicians and prevention workers must know how to help the people they serve gain access to these benefits.
- Work and/or education are basic goals for the majority of people who are homeless. These are sources of significant self-esteem, counteracting demoralization and providing daily structure and a long-term foundation to prevent subsequent homelessness. You will want to be familiar with community resources for vocational and educational training and placement.
- Many people who are homeless have no social supports, but some do—especially those with brief intermittent periods of homelessness. Family or close friends can offer support; be alert to these resources when helping people repair their social networks. For someone with a history of chronic homelessness, you may need to re-conceptualize how to help rebuild his or her social supports.
- People who experience homelessness encounter a range of problems. You can apply the skills gained from serving this population to your work with anyone experiencing biopsychosocial challenges. Conversely, the techniques you have already mastered can be applied in your work with people who are homeless, depending on the stage of change they are in.

Homelessness in America

How Is Homelessness Defined?

There is no single definition of homelessness; however, most Federal homelessness programs use the definition of a homeless individual provided by the McKinney-Vento Act (P.L. 100-77):

> An individual who lacks a fixed, regular, and adequate nighttime residence; and a person who has a nighttime residence that is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings. (42 U.S.C. § 11302)

In other words, a person experiencing homelessness has no fixed place to live and often dwells in public spaces, shelters, or drop-in centers or may double up in others' homes in a temporary or makeshift way. The more recent Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 (P.L. 111-22), which amends the McKinney-Vento Act (see Part 2, Chapter 1, for further detail), expands the definition (Sec 103, 42 U.S.C. § 11302) of a person or family who is homeless to include anyone who:
- Resided in a shelter or place not intended as a home and is now leaving an institution where he or she temporarily resided.
- Is losing his or her housing in 14 days or fewer; cannot obtain housing through his or her support networks or other resources.
- Has, at some point, lacked independent permanent housing for a long period of time; has moved frequently; and is likely to continue doing so as a result of physical disability, mental disorder, addiction, or other barrier.
- Has experienced domestic violence, sexual assault, and/or other dangerous or life-threatening conditions in a housing situation that he or she is leaving.
- Is an unaccompanied youth who is homeless.

HUD (2001) defines a person who is chronically homeless as "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four [4] episodes

of homelessness in the past three [3] years" (p. 6). Unaccompanied individuals who are homeless are men and women not accompanied by children or a partner. Disabling conditions include mental disorders, substance use disorders, and medical conditions.

How Many People Are Homeless?

It is difficult to count the number of people who are homeless accurately because they move frequently. This means they can be counted more than once or missed. HUD has estimated, based on point-in-time counts, that 643,067 persons were homeless at a single point in time in January 2009, of whom 237,934 were on the streets, in abandoned buildings, or in other places not meant for human habitation (HUD, 2010). Sixty-three percent of people who were homeless were single individuals and the rest were members of families experiencing homelessness. Another estimate using these data arrived at a slightly higher number: 656,129, a 3 percent increase over the previous year. The number of families facing homelessness increased by 4 percent over the same period, although the figures are much higher in some States (Sermons & Witte, 2011). The full extent of the effects of the 2008 recession on homelessness may not be measured for some time.

On a single night in 2009, an estimated 75,609 veterans were homeless; 57 percent were staying in an emergency shelter or transitional housing program, and the remaining 43 percent were unsheltered—that is, living on the street, in an abandoned building, or in another place not meant to serve as a human dwelling. Of veterans in shelters, approximately 96 percent were individuals and slightly less than 4 percent were part of a family that was homeless (HUD & VA, 2010). For more information, see the online literature review in Part 3 of this TIP.

Who Is Homeless?

People who are homeless come from all strata of society, although the poor are most certainly overrepresented. The high percentage of people of color in the homeless population is related to their chances of being poor, not to their race/ethnicity (Burt, 2001). The National Survey of Homeless Assistance Providers and Clients (Burt et al., 1999) reported that:

- About 40 percent of clients who are homeless are African American, about 40 percent are White, about 11 percent are Hispanic, and about 8 percent are Native American.
- About 61 percent of clients are men by themselves, 15 percent are women by themselves, 15 percent live with their own children under age 15, and 9 percent live with another adult.
- Clients who are homeless are concentrated in central cities (71 percent), with fewer in urban fringe areas and suburban areas (21 percent) and rural areas (9 percent).

What Factors Contribute to Homelessness?

Both the environment and individual factors contribute to homelessness.

Environmental factors

Poverty predisposes people to homelessness through a range of environmental factors; 5 to 10 percent of people who are poor experience homelessness in a given year (Burt, 2001). Since the 1970s, vulnerability to homelessness has increased among the poor as access to affordable housing, social safety nets (e.g., housing/income subsidies, affordable health care, hospitalization), and adequate income have decreased. In addition:

- Housing costs price many people with below-poverty incomes (e.g., very low-income families and single adults) out of the market (Burt, 2001). More than 14

million families have "worst-case housing needs," defined as spending more than 50 percent of monthly income on rent (Lipman, 2002).

- The removal of institutional supports (e.g., deinstitutionalization) has resulted in fewer housing options for people diagnosed with SMI (Burt, 2001). It is critical that housing issues be addressed in disposition planning when individuals are discharged from inpatient or outpatient mental health or substance abuse treatment settings. Clients leaving intensive treatment settings who do not have adequate housing to support their recovery have a significantly higher risk of relapse.
- Decreased job options for people with high school educations and increasing disparity between minimum wage and cost of living have made it increasingly difficult to earn enough money to afford housing (Burt, 2001).

Environmental factors affecting vulnerability to homelessness relate directly to community resources. Community solutions for preventing homelessness and ending chronic homelessness include affordable housing, access to permanent supportive housing for clients with mental illness and substance use disorders, improved schools, training, prison transition programs, job opportunities, and support services (Burt, 2001).

Individual factors

In addition to substance use and mental disorders, a range of complex, interrelated individual risk factors are related to homelessness, including trauma-related symptoms, cognitive impairment, medical conditions, lack of support from family, limited education and job skills, and incarceration (for more detail, see the literature review in Part 3 of this TIP, which is available online at the KAP Web site (http://kap.samhsa.gov). A significant percentage of individuals who are homeless will likely experience at least one of these issues. For example:

- Mares and Rosenheck (2004) found that veterans who are homeless report that three aspects of their service contributed to their homelessness: substance abuse beginning in the military (75 percent), inadequate preparation for civilian employment (68 percent), and loss of structure (68 percent).
- People who have or have had mood disorders, schizophrenia, antisocial personality disorder, or any substance use disorder are at least two times more likely to have been homeless than those without these diagnoses (Greenberg & Rosenheck, 2010a,b).
- Of people who are homeless and in substance abuse treatment, 68 percent of men and 76 to 100 percent of women report trauma-related events (Christensen et al., 2005; Jainchill et al., 2000), similar to rates reported by general samples of people who are homeless.
- As many as 80 percent of people who are homeless exhibit cognitive impairment, which can affect their social and adaptive functioning and their ability to learn new information and new skills (Spence, Stevens, & Parks, 2004).
- People who are homeless have high rates of HIV/AIDS, hepatitis C, cardiovascular conditions, dental problems, asthma, diabetes, and other medical problems (Klinkenberg et al., 2003; Magura, Nwakeze, Rosenblum, & Joseph, 2000; Schanzer, Dominguez, Shrout, & Caton, 2007).
- Lack of familial support increases the risk of episodic and chronic homelessness and manifests as disconnection from family, childhood placement in foster care or other institutions (27 percent), and childhood physical and/or sexual abuse by family members (25 percent; Burt et al., 1999).

- Thirty-eight percent of people who were homeless and received services in 1996 lacked a high school diploma or equivalent (Burt et al., 1999).
- Incarceration is common among people who have experienced homelessness (54 percent of those who received services in 1996; Burt et al., 1999). Many individuals leaving prison have no place to live and seek housing through community resources for homelessness.

Are There Different Types of Homelessness?

Surveys conducted with people who are homeless indicate that there is a continuum of homelessness (Burt, Aron, Lee, & Valente, 2001). This section offers brief explanations of the types of homelessness, the prevalence of each, and illustrative vignettes.

Transitional homelessness

A first or second episode of homelessness, ranging from a few weeks or months to less than a year, is considered transitional homelessness. About half of the homeless population falls into this category, including many families who are homeless. Families are likely to qualify for public assistance programs, so they are less likely to be homeless or to be homeless for long periods. People leaving prison or jail may be transitionally homeless.

Episodic homelessness

Episodic homelessness means entering and leaving homelessness (e.g., shelters) repeatedly. Between episodes of homelessness, a person might be tenuously housed (in his or her own housing or living with friends/relatives) and at high risk for becoming homeless again. About one fourth of people who are homeless have gone in and out of homelessness numerous times (Burt et al., 2001).

Chronic homelessness

About a quarter of people who are homeless have been continuously so for at least 5 years (Burt et al., 2001). Engaging people who are chronically homeless in housing and other services requires willingness to provide housing and services that are attractive to clients.

How Do Communities Respond to Homelessness?

Homelessness is a broad social problem, and

Mikki

Mikki is **transitionally homeless**. Her boyfriend (who is also the father of her youngest child) has left her. He promised financial support for Mikki and the two children, ages 7 and 3, but only provided money for a few months. Mikki was evicted from her apartment 3 weeks ago and has been living with her children in the family car, which won't start. When the children come down with bad colds, she takes them to the community health center.

Mikki has become progressively more depressed as a result of her breakup and the stress of homelessness. She has begun drinking at night to sleep. The case manager in the community health center helped her arrange temporary emergency housing until more stable transitional or permanent supportive housing can be arranged. He also referred her for a psychiatric evaluation and worked with the school system to provide supportive and preventive services to the children. One of his primary goals has been to intervene before a pattern of long-term homelessness is established. The case manager is also cognizant that Mikki's co-occurring depression and substance abuse must be addressed as part of a larger treatment plan that includes adequate housing, employment, financial support, child care, and services for mental health and substance abuse treatment.

Part 1, Chapter 2, describes how the caseworker helps Mikki obtain these services.

Roxanne

Roxanne is **episodically homeless**. She has a history of illicitly using and selling extended-release oxycodone and other opioid drugs. She has been diagnosed with antisocial personality disorder. She lived with friends until they tired of her drug use and erratic behavior. Roxanne now lives in single room occupancy (SRO) housing. Roxanne's drug use and erratic behavior make it hard for her to hold a job. She occasionally engages in prostitution and sells pain pills for income. She's been told not to bring customers to the SRO but sometimes brings them anyway. Failing to follow the rules puts her at risk of ending up back on the street. Roxanne's behavior and risk of eviction predispose her to victimization. Although currently housed, Roxanne has a long history of episodic homelessness beginning in childhood. As an adult without family, she is ineligible for most safety-net programs, so she is at risk for continued episodic homelessness.

Part 1, Chapter 2, shows how her counselor helps ready her for services to reduce risk of homelessness, address pervasive trauma symptoms that interfere with life functioning, and maintain commitment to mental health and substance abuse treatment and recovery.

communities have established a range of strategies to manage homelessness. On one hand, faced with demands from business owners and other citizens, some public officials have turned to criminal justice solutions to respond to street homelessness. Legal measures include prohibition of sleeping, camping, begging or panhandling, and storing personal possessions in public areas. Other trends restrict serving food to the poor and homeless in public places. Such measures can impede provision of services and create additional barriers to recovery (such as criminal records), which can delay access to housing and decrease eligibility for employment.

On the other hand, a growing number of States and communities are adopting progressive initiatives, including the development of drug, mental health, and homelessness courts, which divert people who are homeless from incarceration; mobile crisis teams working in tandem with police trained to respond to people who are homeless; programs to bridge reentry into the community for people exiting the criminal justice system; and specialized community services, such as crisis intervention beds, sobering stations, and homelessness assistance centers. As of August 2007, more than 300 communities had formal plans to end chronic homelessness (see the U.S. Interagency Council on Homelessness [USICH] Web site at http://www.usich.gov) and were offering a wide range of treatment and housing services to meet this goal.

A particularly progressive initiative is the provision of permanent and transitional supportive housing, which offers stable, safe, affordable, long-term housing for individuals and families who would otherwise be homeless. Permanent supportive housing provides long-term hous-

Francis

Francis is **chronically homeless**. He has lived in a subway tunnel for some time and is known to the staff of the local homeless program. It's been more than 5 years since he had a home. His medical records indicate that he has an intelligence quotient (IQ) of about 70, possible cognitive impairment from an old injury, and diabetes. With cold weather predicted, the outreach and engagement team want to see how he is functioning, if he has immediate needs, and whether he will accept shelter.

Techniques for engaging Francis into appropriate services are illustrated in Part 1, Chapter 2. The importance of cultural competence in working with Francis is shown in the vignette.

ing and supportive services to people with physical disabilities, mental illness, or other long-term impairments (such as developmental disabilities) that limit the individual's ability to maintain housing without assistance. Transitional supportive housing provides stable housing along with social and health services but is more often used with individuals and families in crisis or transition.

PSH helps eligible people find a permanent home and obtain needed mental health and substance abuse treatment services. An important component of PSH is that housing is not contingent on whether an individual obtains mental health, substance abuse, or other services, but rather, allows the individual to decide when and how to seek out services. PSH supports individuals in choosing their own living arrangements and helps them access services based on the support they need at any given time.

An example of a candidate for transitional housing is an individual leaving addiction treatment who has no place to live, needs a sober environment to support recovery, and can be expected to regain employment in the near future. Transitional housing is normally limited to 2 years. Some of the social and health services frequently offered in supportive housing include mental health and substance abuse treatment, employment services, job training, life skills training, interpersonal skills development, medical case management, and coping skills training. Transitional and permanent supportive housing can range from a rooming house with individuals having their own rooms to clusters of small apartments in a single location to scattered-site programs in which rent subsidies are provided for individuals and families to have a home in the greater community.

A major support for persons in need is SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) program. Administered by the Center for Mental Health Services (CMHS), PATH is part of a formula grant to States and provides minimal housing assistance for individuals. PATH funds help individuals with SMI and co-occurring mental and substance use disorders access needed services. PATH provides technical support and funding for outreach, screening and diagnostic treatments, community mental health services, alcohol and drug treatment, staff training, case management, health referrals, job training, and educational and housing services.

There are approximately 600 local PATH organizations that work to engage behavioral health service agencies and housing programs. Nearly all States use money from PATH formula grants to contact and engage people who are disconnected from mainstream resources. This includes collaboration with the Social Security Administration to support access to Social Security Income benefits among homeless populations with mental illness, as well as collaborative planning efforts with local continua of care to coordinate homelessness services and to end homelessness. According to the PATH Web site (http://pathprogram.samhsa.gov/), PATH providers work with service delivery systems and use effective practices by:

- Partnering with Housing First and permanent supportive housing programs.
- Providing flexible consumer-directed and recovery-oriented services.
- Improving access to Social Security and other benefits.
- Employing consumers or supporting consumer-run programs.
- Partnering with medical providers, including Health Care for the Homeless and community health centers, to integrate mental health and medical services.
- Improving access to employment.

- Using technology, such as handheld electronic devices, electronic records, and Homeless Management Information Systems (SAMHSA, n.d.; USICH, 2011).

Vignette 7—Sammy in Part 1, Chapter 2, of this TIP—illustrates how PATH can be of assistance for clients with SMI who are homeless. For more information about PATH, related resources, and a list of PATH grantees, visit the PATH Web site (http://pathprogram.samhsa.gov).

Homelessness and Behavioral Health Services

Behavioral health problems are common among people who are homeless, and the risk of chronic homelessness increases when substance use or mental problems are present. Substantial progress toward recovery and self-sufficiency may require significant engagement efforts and repeated attempts at treatment and housing rehabilitation. In addition, relapse during substance abuse treatment may create barriers to a variety of services, including transitional and permanent supportive housing (Kertesz et al., 2007). Furthermore, clients who relapse and exhibit symptoms of their mental disorder (e.g., a person with bipolar illness who relapses into a manic episode) may find their opportunities for housing restricted. People who are homeless or at risk for homelessness and have a substance use or mental disorder are often cut off from social supports and need services ranging from safe and stable housing, food, and financial assistance to medical care, mental health treatment, child care, education, skills development and other preventive services, employment, screening and early intervention, and recovery support. It is important that you, as a behavioral health service provider, participate in a system of care that responds specifically to your clients' wide-ranging needs. Comprehensive recovery efforts must include not only housing, but also supportive mental health, substance abuse, medical, occupational, and social services.

The Special Rewards of Working With People Who Are Homeless

As a behavioral health service provider, working with individuals who are homeless may mean entering a world you have previously seen only from a distance. It is common to have concerns and anxieties when first beginning to work with people who are homeless. In providing services for this population, you will likely face some complex and challenging problems. At the same time, however, your work with people who are homeless can be quite rewarding; their gains can be dramatic as they move through their personal recovery processes.

For many, working with clients who experience homelessness provides the opportunity to look inside a world that may be very different from their own and to learn life histories that depart substantially from those of most people they know. Living on the streets requires substantial skill, strength, and resourcefulness. People who are homeless have lessons to teach about being survivors in difficult and often hostile environments.

Perhaps surprisingly, some people who are homeless are de facto experts on the service systems in their communities. These individuals have valuable firsthand information about where to go (and not go) to seek food, shelter, medical services, and other resources. You can gather valuable information about community resources from these people.

In working with this population, you have the opportunity to make a real difference for some of your community's most vulnerable and disenfranchised citizens:

- *With your help, a person's immediate risk of harm can be substantially reduced.* Assisting

your clients in obtaining even temporary housing will substantially reduce their risk of victimization, morbidity or mortality from exposure, and exacerbation of mental illness. For clients with existing health problems, temporary housing can mean the opportunity to obtain needed medical care.

- *You can help people realize elusive lifelong goals.* For many persons who are homeless, life in stable housing may feel like a distant or unattainable dream. But this transition can be made, and you can be one of the change agents that makes it happen. See Vignette 1 in Chapter 2 (Juan).
- *You can help people transform their lives.* The difference between being homeless and being housed affects almost all aspects of a person's life, including increasing the likelihood of advancing personal recovery from mental illness and substance abuse, as is the case with René in Vignette 5 in the next chapter, and reducing the risk of future substance abuse and mental disorders, especially for children who are homeless (see Troy and Mikki in Vignettes 4 and 6, Part 1, Chapter 2, of this TIP).
- *You will come to understand, firsthand, one of our Nation's pressing social problems.* The Francises, Roxannes, and Mikkis of your community are not able to work for change, at least not until they are further along in recovery. Working with them and actively helping them navigate and benefit from a layered service system is rewarding work. Moreover, through your experiences and your understanding of their world, you can help improve the behavioral health system that reduces homelessness and the hardships faced by people who are homeless.

Counselor Competencies for Working With People Who Are Homeless

The knowledge, skills, and attitudes for working effectively with people who are homeless in all phases of rehabilitation are presented in this section (see also the Center for Substance Abuse Treatment's [CSAT's] Technical Assistance Publication 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* [CSAT, 2006a] for more information on counselor competencies). Some specific knowledge, skills, and attitudes helpful for your work with clients with a substance use disorder and/or mental illness and facing or experiencing homelessness are listed below. All of the discussion below presumes that you, as a behavioral health service provider, possess sufficient knowledge and skills and appropriate attitudes for working with people with mental illness and/or substance use disorders. Some competencies will be more relevant to either treatment or prevention workers. However, anyone who provides behavioral health services needs at least a basic level of competence in each area discussed in this section to ensure the delivery of *integrated* care and services to the whole person.

Knowledge

To provide effective services to people who are homeless or at risk of becoming so, behavioral health workers should possess knowledge of:

- Homelessness: its impact on people and families, how it acts as a barrier to services for other problems, such as substance abuse and mental illness, and how, without intervention, it can become self-perpetuating.
- How substance abuse, mental illness, and homelessness interact to limit clients' opportunities for growth and change.

- Medical comorbidity in homeless populations and how to help people address physical wellness.
- The pervasiveness of physical and sexual trauma within homeless populations and the effects of trauma in limiting opportunities for recovery from mental illness and substance abuse.
- The effects of experiences of incarceration among clients who are homeless.
- Local homelessness assistance services and available community resources and how to help clients with a mental illness or a substance use disorder access them.
- The process of recovery from substance abuse, mental illness, and homelessness, including appropriate interventions at different stages in recovery.
- The interaction of co-occurring substance use and mental disorders and homelessness.
- Prevention and treatment methods that have been shown to be effective or promising with people with substance abuse and/or mental illness who are homeless.
- The fact that having a substance use disorder or mental illness can itself affect the process of relationship development and trust in others.
- Types of housing services that might be useful and how to access these services.

Skills

Using the following skills will allow behavioral health service providers to work more successfully with clients who are experiencing homelessness or the threat of it:

- Use techniques for creating trusting, collaborative relationships with members of a population that experiences high rates of social disaffiliation; for identifying client strengths; and for helping clients empower themselves to initiate and sustain stable housing and recovery.
- Demonstrate specific outreach skills for people who are homeless, particularly those who are chronically homeless and have a substance use and/or mental disorder.
- Conduct an initial screening and needs assessment for clients who present with a substance use and/or mental disorder and are homeless or are facing homelessness.
- Recognize the effects of psychological trauma on trust, willingness to persevere and accept help from others, and a variety of other personal and interpersonal dynamics that are important in treatment and recovery.
- Support clients' early changes (e.g., entering treatment, recognizing/addressing mental and substance use disorders, finding temporary housing, obtaining needed medical care, getting financial support).
- Develop person-centered treatment and/or prevention plans that consider the whole person and his/her individual needs, including early intervention for emerging mental and substance abuse problems, mental illness and substance abuse treatment and rehabilitation, and programming to build resiliency and enhance quality of life by developing social and occupational skills.
- Use case management skills in helping people make contact with and continue accessing needed community resources, including prevention programs.
- Retain clients in treatment and prevention programs by maintaining rapport, motivation, and hope and by helping them work through the obstacles they face in recovery.
- Develop realistic, individualized relapse prevention and recovery management plans that include specific "how-to" steps to follow if the client experiences a recurrence of behavioral health symptoms, homelessness, or other life problems.

- Collaborate with other service providers, family members, and social supports to:
  - Help people who are homeless access services.
  - Better understand needs and strengths.
  - Ensure appropriate care and smooth transitions.

Attitudes

Behavioral health workers engaged in providing services to clients who are dealing with homelessness can benefit from certain attitudes. For example:

- Accept and understand powerful emotional responses to client behavior and address these responses in supervision.
- As a precondition to a positive working relationship, meet clients where they *are* rather than where they *should be*.
- Appreciate that people must assume responsibility for their own recovery trajectories, although they sometimes make choices that do not appear to be in their own best interests.
- Trust that change begins with small steps that are self-reinforcing and aggregate to larger changes.
- Understand that all change is incremental and that many clients who are experiencing homelessness are on a long recovery pathway.
- Recognize that consistency and reliability can counteract the disaffiliation and mistrust experienced by many persons who are homeless and have substance use or mental disorders.
- Appreciate that work with people who are homeless and in need of treatment requires collaboration and cooperation among a range of service professionals and peer supports.

Self-Assessment of Attitudes Toward People Who Are Homeless

Attitudes toward homelessness, substance abuse, and mental illness vary widely. Many of these beliefs originate in childhood and influence your perception of these problems. These perceptions, whether beneficial or limiting, tend to be reinforced as you encounter people dealing with substance use or mental disorders and homelessness. It is important for you to be particularly aware of your attitudes and beliefs regarding these topics. Likewise, it is important to remember that not everyone holds your particular views or attitudes.

Behavioral health service providers work with people who are homeless and have a substance abuse or mental health diagnosis in many different settings: street outreach, mobile crisis teams, drop-in centers, shelters, assertive community treatment (ACT) teams (see p. 143), permanent supportive housing programs, criminal justice environments, healthcare facilities, and other community behavioral health prevention and treatment programs. This work presents many challenges along with opportunities for professional growth. One of the important challenges is to monitor and be aware of your personal attitudes and beliefs about your clients. This section presents:

- Opportunities to consider your reactions to and assumptions about people who are homeless.
- Myths people often believe about people experiencing homelessness.
- Methods for managing responses when working with this population.

Reactions and assumptions about people who are homeless

Three people with mental or substance use disorders who are homeless were described earlier in this chapter. Your reactions, assumptions,

and beliefs influence how you might interact with each one. After reading their descriptions, some of the reactions you might experience as you imagine a conversation with Mikki, Roxanne, or Francis include:

- Empathy (I have an emotional understanding of what it's like to be in his or her shoes).
- Sympathy (I feel sorry for him or her).
- Fault finding (Why doesn't he or she… like everyone else?).
- Curiosity (I wonder what his or her story is?).
- Aversion (I don't want to meet him or her).
- Fear (This person may hurt me in some way).

Your personal experiences and history play an important role in how you perceive and work with people who are homeless and have substance use or mental disorders. Ask yourself the following:

- What is my personal and family experience with substance abuse, trauma, mental illness, and homelessness?
- What personal experiences do I have with these problems, and how do those personal experiences—for better or worse—affect my work?
- What is my emotional reaction to people who have a mental or substance use disorder and are homeless?
- How comfortable do I feel providing services to people with these problems, and what are the areas of discomfort that I experience?
- What did I learn about homelessness, substance use, and mental illness growing up?
- What beliefs and attitudes do I hold today that might challenge or limit my work with persons who are homeless and have a substance use or mental disorder?

Myths and realities about people who are homeless

When providers have insufficient information about social and health problems, myths may arise about the nature of the problems, the kinds of people who are likely to be affected by them, and how the problems are best addressed. Homelessness, and the relationship between homelessness and behavioral health problems, are not exceptions. Care providers are not exempt from the myths that universally abound. Your awareness and management of attitudes and beliefs that may interfere with your work will result in personal growth and better relationships with clients. Following are some common myths about people who are homeless.

Myth #1. People choose to be homeless.

Reality: Most people who are homeless want what most people want: to support themselves, have jobs, have attractive and safe housing, be healthy, and help their children do well in school.

Myth #2. Housing is a reward for abstinence and medication compliance, and society shouldn't house people who have active substance use or mental disorders.

Reality: Housing may be the first step to becoming abstinent and/or entering treatment to address a variety of problems. From a public health perspective, adequate housing reduces victimization, hypothermia or hyperthermia, infectious diseases, and other risks to the population as a whole.

Myth #3. People who are homeless are unemployed.

Reality: Many people who are homeless are employed full or part time. According to data from the National Survey of Homeless Assistance Providers and Clients (Burt et al., 1999), 44 percent of people who were homeless and

received services did some work for pay in the month before being surveyed. A single-day count of people who were homeless in an urban area of Washington State found that 20 percent were employed at least part time (Putnam, Shamseldin, Rumpf, Wertheimer, & Rio, 2007).

Myth #4. There are few homeless families.

Reality: To describe the full impact of homelessness, episodes of homelessness, and the effects on children of tenuous living situations (such as the "doubling up" of one family in the home of another family), the National Center on Family Homelessness (NCFH) used refined methods for estimating the number of children exposed to these burdensome and stressful difficulties. NCFH determined that in 2010, 1.6 million children in America were exposed over the course of the year and 200,000 on any given night (NCFH, 2010).

Myth #5. People who are homeless aren't smart enough to make it.

Reality: Keeping things together while homeless takes ingenuity and experience. People

The Impact of Homelessness on Children and Families

Homelessness results in a loss of community, routines, possessions, privacy, and security. Children, mothers, and families who live in shelters must make significant adjustments to shelter living and are faced with other problems, such as feeling ashamed of being homeless and accepting help, the anger and confusion of being relocated, and having to adjust to a new school and other new routines.

The stress related to these risks adds to the stress resulting from homelessness itself and can impede recovery due to ongoing traumatic reminders and challenges:

- The experience of homelessness puts families at greater risk of additional traumatic experiences, such as assault, witnessing violence, or abrupt separation.
- Children, parents, and families are stressed not only by the nature of shelter living and the need to reestablish a home, but also by interpersonal difficulties, mental and physical problems, and child-related difficulties such as illness.
- The stresses associated with homelessness can worsen other trauma-related difficulties and interfere with recovery due to ongoing traumatic reminders and challenges.

Children are especially affected by homelessness:

- Children who are homeless are sick twice as often as other children and suffer twice as many ear infections, four times the rate of asthma, and five times more diarrhea and stomach problems.
- Children who are homeless go hungry twice as often as children who have homes.
- More than one fifth of preschoolers who are homeless have emotional problems serious enough to require professional care; less than a third receive any treatment.
- Children who are homeless are twice as likely to repeat a grade as those with homes.
- Children who are homeless have twice the rate of learning disabilities and three times the rate of emotional and behavioral problems compared with children who are not homeless.
- Half of school-age children who are homeless experience anxiety, depression, or withdrawal compared with 18 percent of children who are not homeless.
- A third of children over age 8 who are homeless have a major mental disorder.

These are not only challenges in themselves, but also may act as "secondary adversities," putting a child at greater risk for trauma reactions and making recovery difficult. For more information and a list of resources about providing care and improving access to services for children and families who have been traumatized and/or are homeless, visit the National Child Traumatic Stress Network Web site (http://www.NCTSNet.org).

Source: Bassuk & Friedman, 2005.

who are homeless often have well-developed street skills, resourcefulness, and knowledge of the service system.

Myth #6. Those with substance use or mental disorders need to "bottom out," so homelessness is okay and provides a motivator to make behavioral changes.

Reality: People who have substance use and mental disorders are more responsive to interventions before they become homeless or when placed in housing.

Myth #7. Everyone stands an equal risk of homelessness.

Reality: Although any of us could find ourselves homeless in our lifetime, some people are at higher risk than others. If we can identify people at special risk of homelessness, we may be able to intervene earlier and prevent the devastating effects experienced by people who are homeless and have accompanying mental and/or substance use disorders.

Myth #8. All clients with substance use and mental disorders who are homeless require extensive, long-term care.

Reality: The process of recovery from substance abuse and mental illness is an ongoing and sometimes lifelong process, yet healing often begins with short-term, strategic interventions. Screening, brief intervention, and referral to treatment (SBIRT; see the section on p. 35 for more information) is a proven method for early intervention with substance use and mental disorders, and it can significantly reduce the impact and progression of illness.

Self-Care for the Behavioral Health Service Worker

The intensity of the work with people who are homeless and have mental and/or substance use disorders can lead to burnout, ethical dilemmas, and a sense of being overwhelmed by your work. Your personal history is unique; however, commonalities of experience in working with people who are homeless allow some generalizations about the need for self-care. Some of the actions you can take are consistent across a variety of roles, personalities, and circumstances.

Common responses to working with people who are homeless

Working with people who are homeless may entail addressing emergency situations, complex case management demands, severe and persistent symptoms, and refusal of services. The pace of the work may be a stressor, as some people who are homeless are reluctant to engage in services and require a lot of time and patience to develop trusting relationships. You may experience stress or unrealistic expectations when working with this population. Other common reactions include:

- Considerable anxiety regarding clients in dangerous situations (e.g., refusing shelter on frigid nights).
- A strong desire to repeatedly try to persuade someone to go to treatment because you are concerned about his or her pace in recovery.
- Frustration and strong urges to use involuntary measures (e.g., police transport to the hospital) despite no clear risk of imminent danger to self/others when a severely impaired person is slow to engage.
- Conflict over family members' reactions, given their experience (e.g., burnt bridges, extreme feelings of guilt) with an individual's past behavior.
- Feeling overwhelmed or frightened by your client's irritability, anger, and frustration. An example of deescalating a person in the midst of an intense emotional reaction is given in Vignette 3 (Roxanne, Part 1, Chapter 2).

- Thinking about violating ethical boundaries or agency policies to meet the immediate needs of a person who is homeless (e.g., give them personal funds). Feelings of helplessness or a sense of guilt about a person's situation may add to the temptation to violate boundaries and policies.
- A struggle to understand and appreciate the survival skills of a person who is homeless, particularly when his or her choices and behaviors (e.g., distrust, agitation) create barriers to receiving services.
- Guilt about going home at night while a client is sleeping on the street.
- Anger or frustration about missed appointments, which indicate resistance to engaging with services.
- Reluctance to continue providing services to someone whose priorities conflict with your ideas about their needs (priority to find drugs rather than adequate housing, resistance to obtaining medical care for an immediate problem).
- Frustration and feelings of ineffectiveness when your efforts to help seem to be unappreciated.
- A sense of disconnection from clients who seem demanding, needy, miserable, or overwhelmed.

Your own experiences also play a role in your responses to people who are homeless, and these experiences may interfere with your work, particularly if:

- A member of your family has a substance use or mental disorder and/or has experienced homelessness.
- You have trouble differentiating your own recovery process from that of your client.
- You have ever been homeless or faced with the prospect of being homeless.
- You see yourself as someone who has overcome the odds and pulled yourself up "by the bootstraps."
- It is difficult for you to work with people who are overtly angry, excessively passive, or insistent about doing things their way.
- The experience of working with people who are homeless is new to you.

Whether or not you have had these types of personal experiences, you may struggle with your reactions when working with this population, especially when dealing with stressful situations.

Managing responses to working with people who are homeless

Managing your responses to feelings and stressors is easier if you develop and maintain sources of personal support (CSAT, 2006a):

- Learn to recognize when you need help (both technical and personal); ask for it.
- Work in teams and establish networks; discuss feelings and issues with teammates to lower stress and maintain objectivity.
- Be open and sensitive to differences of attitude or opinion among your colleagues regarding individuals who are homeless and the problems they face.
- When you find yourself being angry, critical, or dismissive toward the feelings or needs of a person who is homeless, consider whether this is a sign of an attitude conflict, job burnout, or some other dynamic related to your work.
- Work closely with your supervisor and be open about any difficulties (for more information about the benefits and process of clinical supervision, refer to TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor* [CSAT, 2009b]).

Managing feelings and stressors is easier if you maintain healthy boundaries between your work and personal life:

- Resist the urge to bring work home.

- Don't spend your free time at work or with your clients.
- Resist the urge to be a friend or feel responsible for rescuing the people you serve from homelessness.
- Recognize that your role is to help people help themselves and enable them to address their life problems, not to take responsibility for their problems.

Stages of Change, Recovery, and Rehabilitation

This section presents several frameworks for helping people who are homeless by describing three important aspects of a trajectory out of homelessness:

- Stages of change (Prochaska, DiClemente, & Norcross, 1992). This transtheoretical model describes the process of behavioral change, beginning with precontemplation and continuing through maintenance. It is often used to reflect the process of change for people with substance use disorders.
- Critical stages of recovery (Townsend, Boyd, Griffin, & Hicks, 2000). The critical stages of recovery model, often applied to describe the change process with serious mental illness, emphasizes social and interpersonal connectedness and the relationship of the individual with systems that provide care. The model describes movement through four levels, from dependence through interdependence.
- Stages of homelessness rehabilitation (McQuistion & Gillig, 2006). This model describes the logical progression of rehabilitation—a process of moving from engagement though intensive care and into ongoing rehabilitation. It describes the consequences of homelessness in a holistic manner, recognizing that homelessness is not only the lack of adequate housing but also the psychological, emotional, occupational, interpersonal, health, and other effects on an individual's or family's ability to function.

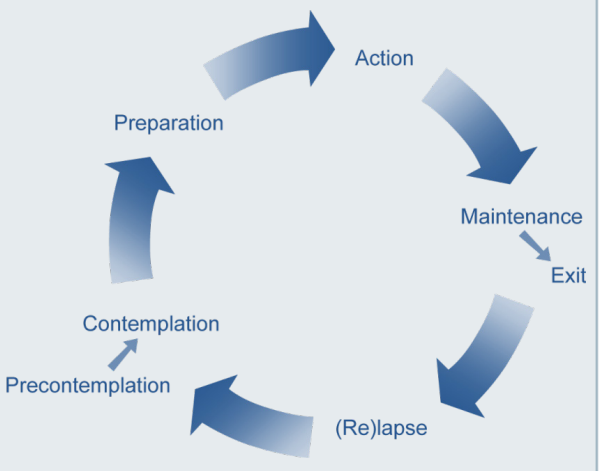
Stages of Change

Stages of change, which comprise the key organizing construct of the transtheoretical model of change, inform effective interventions to promote behavior change. Although they have traditionally been associated with substance misuse, they may also be applied to a person's experience in coming to grips with serious mental illness. The stages of change are equally applicable to prevention or treatment interventions, although in prevention, behavior change may involve risk or protective factors (e.g., parenting skills, physical inactivity) rather than problem behavior per se.

Most people cycle through the stages more than once, and movement through the stages can fluctuate back and forth (Exhibit 1-3). The stages are:

- Precontemplation—Clients view behavior (e.g., substance use, psychological symptoms, healthcare choices) as unproblematic and do not intend to change. Your focus

Exhibit 1-3: Stages of Change



Source: Prochaska & DiClemente, 1986. Adapted with permission.

on changing behavior at this stage may alienate clients. Instead, appropriate interventions help clients engage in services and become ready to consider change.
- Contemplation—Clients think about whether to change behavior, become aware of problems their behavior causes, and experience ambivalence about their behavior.
- Preparation—Clients decide to make a change and have perhaps already begun to change problematic behavior.
- Action—Clients make a clear commitment to change; they engage in activities as alternatives to problem behaviors, avoid high-risk situations, and develop relationships that reward their changed behavior.
- Maintenance—Clients have sustained new behaviors for at least 6 months. They sustain and further incorporate changes achieved in the action stage and are actively working on supporting their recovery.

Two other stages of the transtheoretical model are sometimes identified: relapse and termination. Relapse is a return to problem behaviors. Most relapses to substance use occur within 3 months of behavior change; risk of relapse then begins to decline (Connors, Donovan, & DiClemente, 2001). Termination occurs when new behaviors are thoroughly stabilized and there is a compelling belief that a return to the problem behavior is highly unlikely (see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999b] for an indepth discussion of stages of change).

Regardless of the model for understanding change, it is important to remember that people are often in different stages of change for different issues. For example, a person may be willing to accept housing or medical care (preparation stage of the transtheoretical model) while not yet thinking about substance abuse or mental health treatment or broadening coping skills or community involvement (precontemplation stage). The provider's challenge is to understand and respect the service recipient's stage of readiness and provide interventions and services that facilitate forward movement. Skilled providers recognize that readiness to change some behaviors might provide an opportunity to explore ambivalence and enhance readiness to change others; for example, persons may be willing to seek housing but not immediately address substance use behavior. When they do recognize that housing issues are intertwined with substance use, they may be more willing to explore the pros and cons of their use.

As people move toward the action stages in any model, they become ready for more intense services, which often require more active collaboration with clients and may be offered in more structured housing and treatment or prevention programs where individual responsibility for completion of tasks and behavior change yields successful outcomes.

Critical Stages of Recovery

Whereas the stages of change model addresses psychological readiness for behavioral change, the stages of recovery model addresses developmental goals that are more closely related to mental health recovery, the degree and nature of social connectedness, and the relationship between an individual and the service delivery system. As clients engage in their recovery process, they begin in a state marked by high dependence on the human services system and other community supports but are paradoxically unaware of that dependence. As they gain greater mastery over their recovery, they may remain dependent on support from others, yet become *aware* of that dependence. Following this is a stage of awareness and relative *independence* from these structures, and finally, a stage characterized by a sense of *interdependence,* in which they are aware of challenges and can use natural support systems, both formal

and informal, realizing that they are also actively contributing to the social environment. (Townsend et al., 2000.)

The stages of recovery model recognizes the right of people to live in the community and to choose their lifestyle. It is premised on a number of additional guiding principles. Perhaps most important is that a client directs and manages his or her recovery process. A corollary of that is that behavioral health service providers need to be wary of their tendency to encourage clients to be dependent on the treatment system (Townsend et al., 2000). As part of a community system of care, the behavioral health service provider has an important role in each of these stages to promote recovery (Exhibit 1-4).

Processes in recovery from substance use and mental disorders

In recovery, people actively manage substance use and/or mental disorders and seek to transcend these experiences as they build or reclaim meaningful lives in the community (Davidson

Exhibit 1-4: Behavioral Health Service Provider Roles and Best Practices According to Stage of Recovery

Stage	Service Provider's Role	Best Practices To Facilitate Recovery
Dependent/Unaware	• Demonstrate hope • Encourage self-acceptance • Educate about behavioral health problems and the benefits of a recovery plan • Engage family and other social supports	• Build relationship by listening, valuing, and accepting client as a worthwhile person • Collaborate with client in managing behavioral health problems • Build rapport with family/others • Link to services and benefits
Dependent/Aware	• Promote readiness to make choices about life roles/goals • Educate family about available choices • Offer support in designing a recovery plan	• Involve client with groups that address his or her specific needs • Educate about behavioral health problems and relevant coping skills • Help with choosing goals
Independent/Aware	• Help develop life roles/goals • Encourage individual coping strategies to deal with symptoms and distressing experiences • Support medication management and use of recovery plan • Encourage appropriate support from families and others	• Assist with connection to community resources • Work on recovery plan, recovery support, coping skills, and crisis plan
Interdependent/ Aware	• Work with client and support system to support life goals • Help with community resources • Review recovery plan regularly • Support interdependence in community	• Support continuing recovery • Advocate use of community resources • Encourage involvement in community activities

Source: Townsend et al., 2000.

& White, 2007). The term "recovery" may have somewhat different meanings in substance abuse treatment settings than it does in mental health settings. For instance, many clients in substance abuse recovery may say they are never fully recovered from their illness and are "only one drink away from a drunk," whereas individuals with a single major depressive episode in their history may consider themselves recovered, even "cured" of their illness. In either case, it is important to know how each individual client understands these terms and how they apply to the recovery process for the specific individual.

Considering the broader framework of recovery—integrating the recovery process from substance use disorders with that of mental disorders—Davidson et al. (2008) obtained information from people in recovery about their experiences. For most of the respondents, recovery meant taking an active role, profoundly changing the way they lived their lives, opening up to new learning, and becoming more flexible. The processes the authors describe are presented in Exhibit 1-5. The authors recognize that recovery is not linear, but they believe that processes represented together on a single line in the exhibit occur more or less simultaneously. This progression also suggests that some recovery strategies may be more useful at some points in the process than others. For example, early in recovery, a behavioral health service provider might want to focus on strengthening mutual support systems and fostering a belief in recovery.

These processes are also valid for clients entering homelessness services from the criminal justice system. Developed in partnership with people in recovery, these processes reflect challenges people face in recovery and solutions for them. Your role and that of the program administrator is to help articulate and then support clients' efforts in recovery by helping them identify acceptable strategies and resources to confront these challenges.

Prevention activities can play a central role in recovery, especially those that relate to skills

Exhibit 1-5: Substance Use and Mental Disorder Recovery Processes

Source: Davidson et al., 2008.

development and wellness self-management. In addition, prevention programs can adopt and benefit from a recovery orientation when working with individuals who are homeless.

The process, dynamics, and important interventions related to recovery are addressed in detail in the planned TIPs, *Building Health, Wellness, and Quality of Life for Sustained Recovery* (SAMHSA, planned b) and *Recovery in Behavioral Health Services* (SAMHSA, planned e). Refer to these TIPs for more information on supporting long-term recovery.

Stages of Homelessness Rehabilitation

Stages of homelessness rehabilitation refer to the different types of care a client with behavioral health problems, and his or her family, may receive while moving toward housing stability. Your work may involve clients at any of these stages. For individuals who are homeless, attaining housing and financial stability are inextricably tied to other aspects of social support and to rehabilitation from disabling behavioral health conditions. Depending on the services an individual who is homeless needs, stagewise interventions may emphasize outreach and case management, screening and evaluation, crisis intervention, clinical preventive services, preparation for treatment, treatment planning, relapse prevention or recovery promotion, or ongoing counseling.

Your existing skills in providing treatment and prevention services in behavioral health settings will be invaluable and can often translate directly into working with people with mental and/or substance use disorders who are homeless. Nevertheless, you may need to develop some specific skills for work in this area. It will be necessary to coordinate your services with those provided by staff in other homelessness programs and health and social service organizations. Your services and the services provided by other health and social service organizations are often delivered across stages, with service transition points being particularly high-risk periods for dropout. The stages of homelessness rehabilitation are:

- Outreach and engagement.
- Transition to intensive care.
- Intensive care.
- Transition to ongoing rehabilitation.
- Ongoing rehabilitation.

The amount of time a person spends in any of the stages of homelessness rehabilitation depends on barriers to providing and accepting services—such as availability of appropriate housing options, severity and chronicity of substance use disorders and symptoms of mental illness, and availability and acceptability of social supports for changing problematic behaviors. Progress through the stages of rehabilitation is not steady. Clients may drop out, relapse in their substance use, and need outreach and reengagement several times before achieving ongoing homelessness rehabilitation. For this reason, this TIP assumes that motivation for changing problematic behaviors will fluctuate, that behavioral health symptoms may recur, and that a client may return to homelessness during any phase of rehabilitation.

Outreach and engagement

Engagement is the first stage of work with people who are homeless (McQuistion, Felix, & Samuels, 2008). Its goal is to facilitate the individual's movement through the early stages of behavior change (Prochaska et al., 1992). Approaches during this phase include active outreach to prospective clients and engagement services—including capturing prospective clients' interest in a variety of homelessness services, as well as substance abuse, medical, mental health, and social services; gaining the prospective client's trust; and increasing motivation for change. For families

who are homeless, the prospect of preventive services for children may be especially attractive. During this process, you should identify and attempt to meet basic needs for shelter and safety, and you should attend to immediate health concerns.

For some persons who are homeless or at risk for becoming so—those coming from criminal justice settings or those being discharged from treatment programs—outreach may not be a particularly difficult issue, but engagement in social, health, and continuing prevention and recovery services may present more of a problem. Persons with transitional homelessness may not perceive the need for additional services beyond lodging, seeing their stay in a shelter or other homeless housing program unrealistically as a temporary transition to getting a place of their own. Additionally, clients recently in treatment for mental and substance use disorders may not recognize the effect of their impending homelessness on substance abuse and mental health recovery and across all other aspects of their lives.

As a behavioral health worker, you can play an important role in outreach by acknowledging homelessness as a significant element in when and how people can access treatment, by recognizing the needs of people who are homeless for preventive and basic services, and by developing productive, trusting, and supportive relationships with people who are homeless and come to you for services.

Transition to intensive care

People enter the intensive care phase of homelessness rehabilitation when they agree to accept health and/or financial benefits; medical, substance abuse, and/or mental illness treatment and prevention services; and, frequently, housing. This transitional phase is a high-risk period during which a large percentage of individuals drop out of services. The transitional phase requires intensive support (e.g., intensive case management, critical time intervention) and your acceptance that some people may have increased ambivalence and may not attend program sessions or keep appointments or commitments. Essential elements in this phase include locating clients or program participants when they fail to make contact, making phone calls, and providing immediate tangible benefits (e.g., food, safe shelter, bus fare).

Accordingly, you may have to adapt traditional assumptions about and approaches to service provision when a client is in the transitional phase of homelessness rehabilitation (e.g., assuming clients will make and keep appointments; assuming program participants will attend sessions; assuming individuals have transportation to service settings; having standard time lengths for counseling, psychoeducational, or anticipatory guidance sessions). You may need to exercise greater persistence and advocacy with these individuals. On the other hand, the skills you regularly use, such as maintaining a trusting and supportive relationship, working with resistance, or adapting to specific needs or concerns can be a significant benefit in working with individuals in this stage who are homeless.

Intensive care

As its name denotes, the primary focus of intensive care is a comprehensive but carefully synchronized orchestration of homelessness rehabilitation, including treatment for mental and substance use disorders, access to benefits, active attention to medical problems, housing access, and preventive services, such as assessment of and training in necessary skills (e.g., money management, parenting, employment, and other life skills). Cattan and Tilford (2006) suggest that for younger people who are homeless, including young adults, mental health promotion activities that help create a sense of community and empowerment may

be particularly important. Thus, prevention activities at this stage may include encouraging participation in positive community activities (e.g., sports and the arts) and community service.

Intensive care is implemented in a manner that emphasizes clients' participation in defining and managing their own goals. People in intensive care may drop out or return to homelessness and need to be reengaged several times. In some cases, people verbalize this choice; in others, it is evidenced by angry outbursts, disappearance from services, rule violations, or other behaviors. Appropriate responses include respecting personal choices, attempting to reengage, welcoming the person back, and revising treatment and prevention plans when he or she returns. Some people in this phase will accept higher intensity transitional housing models combined with behavioral health services as well as social and medical services. Others will only accept options that provide housing and voluntary participation in supportive services.

It is important in the intensive care phase of homelessness rehabilitation to ensure that people maintain the gains they have made through previous substance abuse and mental health services. Maintaining momentum for recovery and relapse prevention, continued use of new skills, and involvement in community activities can be essential at this point. Staying in touch with mental health, substance abuse, and other resources in the community is critical, even given transportation problems, employment considerations, multiple pressing needs, and financial constraints.

This phase requires behavioral health services that are integrated with other ongoing housing, healthcare, legal, and social services. Close collaboration among all providers is a priority. The case management skills that treatment professionals use are highly applicable to serving these clients.

Transition from intensive care to ongoing rehabilitation

Before individuals move into the ongoing homelessness rehabilitation phase (when they are preparing for optimal social reintegration), it is important to ensure that they have a comprehensive and evolving plan for sustaining the process of recovery, including acquisition of stable housing, gains made in social and other skills, and involvement in community activities. Successful plans also include a realistic long-term plan for relapse and homelessness prevention, development of strong connections to social supports (e.g., family, faith, and recovery communities), stable income and health benefits (e.g., job skills and employment, health insurance, Federal disability benefits, local government cash supports, veterans benefits, food stamps), and meaningful daily activities that complement their recovery plans.

Making the transition from intensive care to the open-ended stage of ongoing rehabilitation takes time. Increased risk of dropout from services (including behavioral health services) because of increased ambivalence is common and can be addressed by providing increased case management services, staff attention, incentives to remain engaged (e.g., paid vocational services contingent on abstinence and positive work behaviors, transportation), and increased relapse prevention efforts.

Some people may attain such improved functioning, coping skills, social support, and financial resources that they can maintain independent, affordable housing with follow-up services to ensure their gains in recovery and other areas of functioning. Others may benefit from 1 to 2 years or more of a supportive recovery and housing environment (e.g.,

Oxford Houses) to develop better coping skills for maintaining recovery and improving social functioning. Still others need weekly contact with a case manager from a multidisciplinary, community-based team to address any threats to housing stability and recovery as they arise. Transportation issues that limit participation in ongoing rehabilitation activities must also be addressed prior to exiting this phase.

Behavioral health counseling and anticipatory collaborative problem-solving for clients in transition to ongoing rehabilitation are particularly important. Helping clients stabilize in recovery, engage and maintain attendance in self-help programs, develop a realistic individualized relapse prevention/recovery promotion program, and begin to develop a healthy lifestyle are also important at this point.

Ongoing rehabilitation

Ongoing rehabilitation is an open-ended phase in which people gradually establish an identity as no longer homeless (McQuistion et al., 2008). This stage includes an active and continuing supportive counseling relationship and continued participation in prevention programs as appropriate (e.g., regular follow-up meetings to address any problems related to housing stability and recovery). In this stage, clients have a contact person in case of a crisis or relapse.

You can play a significant role as the program participant begins to depend less on services and service providers for assistance. Your consistent, ongoing collaborative relationship with clients may be especially beneficial as their self-concept, expectations for the future, self-esteem, and ability to manage life's problems evolve. Your support for the person's continued attendance at 12-Step and other wellness self-management programs and involvement in new community activities is also helpful. You can be a role model for appropriate absinent behavior and help people share with others what they have learned in their transition from homelessness to an interdependent relationship with their environments.

Clinical Interventions and Strategies for Serving People Who Are Homeless

Behavioral health service providers working with people who experience homelessness need special skills. Specific knowledge about homelessness and its effect on recovery and change is important, as is careful assessment and modification of attitudes that affect your work with this population. Understanding the cultural context of clients and having the skills to adapt to a variety of cultures of people who are homeless is very important. The skills you normally use in providing behavioral health services are applicable but may also need to be modified or honed to address the specific needs of people experiencing or facing homelessness.

It is beyond the scope of most behavioral health programs to meet many of the urgent needs of people who are homeless. Inevitably, this means that you—who may be the point of contact or "first door" for a person who is homeless or facing homelessness—must have a working knowledge of resources in the community for these people, not only for housing services, but also for services that address physical health care, financial crises, criminal justice constraints, and dietary needs, among other concerns. Ideally, a behavioral health program will maintain reciprocal alliances with other community resources that allow for efficient case management of persons with complex needs.

Additionally, people who are homeless may have special mental health and substance abuse treatment needs, including special trauma-informed treatment services, specialized

care for co-occurring disorders, services to ensure medication management, and close medical supervision while undergoing detoxification.

If not already integrated into programming, treatment programs must include prevention programs in their alliances, because many of these programs are designed to meet high-priority needs of persons and families who are homeless (e.g., skills development, parenting education, expanding recreational opportunities, community involvement). Larger programs, especially treatment programs, may also have a designated case management staff member who coordinates referrals and ensures that clients follow through on referrals and that services are provided.

This TIP discusses seven activities common to many behavioral health service situations along with special adaptations that are useful in working with people who are homeless:

- Outreach
- Initial screening and evaluation
- Early interventions and stabilization
- Treatment and prevention planning
- Case management
- Client retention and maintenance of continuity of care
- Relapse prevention and recovery management

Some of these areas may be more applicable to some settings than others, but unless you work in a very specialized setting, all will probably be applicable to your current or future work.

Outreach

Outreach plays a crucial role in work with people who are experiencing homelessness. It means making contact with individuals on their terms—where they live—rather than in an agency setting. It involves developing sufficient trust to help people consider receiving services and the benefits they might accrue from them. It may well mean developing rapport with people who, because of their experiences, have no expectation of a positive outcome.

Outreach is particularly relevant to the engagement stage of homelessness rehabilitation. It involves deliberately and methodically cultivating a relationship with the person or family who is homeless. Effective outreach skills include:

- Expressing appreciation for survival skills as strengths and coping mechanisms.
- Understanding substance abuse and/or psychological symptoms from the client's perspective and understanding how those symptoms are interrelated.
- Addressing financial and health benefits as well as food, healthcare, housing, and other immediate needs.
- Expressing optimism that together you can create a plan that meets the person's needs.
- Empowering the client to set goals and create a plan for recovery and growth.

You will probably find that outreach efforts with people experiencing homelessness are more aggressive and proactive than those you use in traditional mental health and substance abuse settings. You may find yourself meeting your clients literally where they are rather than waiting for them to come to you. While taking care to respect people's autonomy, you may be more assertive in engaging people into services. In treatment settings, you may be more assertive in establishing the therapeutic relationship. You may find yourself responding more actively to crises or becoming more involved than you would with most treatment clients or prevention program participants. In effect, the skills of outreach are generic, but how you apply those skills may be different from your traditional role.

Initial Screening and Evaluation

This activity will generally be different for treatment and prevention professionals. Within prevention settings, a first contact with a person who is homeless may differ little from your first contact with other program participants. However, you will wish to pay special attention to constraints on participation (transportation, child care, etc.) and assist participants who are homeless in addressing these issues. Within your zone of comfort, you may also want to inquire as to other services that your program participant is receiving and suggest community resources where additional services may be accessed.

Within treatment settings, a first contact with a person who is homeless or facing homelessness will ordinarily involve initial observations and, potentially, decisions about care. For instance, although a prospective client may not be forthcoming with information, it may fall to you to evaluate whether the individual is in immediate danger with consequences to health or safety as a result of his or her life situation. You might be in the position of having to determine whether the client needs immediate care as a result of drug use or mental illness or to evaluate his or her ability to make decisions about care. Frequently, it will be necessary to determine which other team members or program staff persons might be helpful in determining urgent client needs (e.g., primary care provider, housing specialist, other mental health professional).

People who are homeless typically engage gradually with services as trust is established. As opposed to techniques in more traditional settings (whether focused on treatment or prevention), gathering information may take more time and be ongoing; new information may surface as the client stays connected. To understand the client's level of functioning and identify appropriate services, screening and evaluation should gather information about:

- Substance use and/or mental disorders, including:
  - Evidence of a substance use disorder, which can include quantity and frequency of use, compulsive use, craving, and problems related to drug use.
  - The effect of specific symptoms (e.g., paranoid thinking, undue grandiosity, constraints resulting from depression) on a client's ability to seek and accept help with housing and other services.
  - Problematic substance use, symptoms of mental disorders, and client readiness for changing substance use behaviors and other areas of social functioning; specific screening instruments can be used to determine each of these.
  - Screening for the presence of a disorder (positive screens should be referred for further assessment and formal diagnosis).
  - The possibility of co-occurring mental and substance use disorders and the implications of co-occurring disorders for immediate and extended treatment and recovery.
- Current and past exposure to trauma and related safety issues.
- Primary care records, history of medical conditions and hospitalizations, list of previous and current medications, and the current need for medical and dental care, including risk of and treatment for HIV/AIDS and other communicable diseases.
- Onset and course of homelessness and how it relates to the course of other symptoms.
- Current skills and ability to maintain stable housing.
- Current and/or pressing criminal justice issues, including outstanding warrants that

might lead to incarceration; probation and parole status; and current behaviors that, if discovered, might lead to arrest.
- Social functioning in terms of social supports, literacy, education, job skills, employment, and income, as well as:
  - The client's family (as he or she defines it) and other social supports that the client wants to incorporate into the plan for recovery.
  - Immediate stressors (e.g., shelter living, housing instability, lack of money, debt, legal issues).
- Client interest in prevention-related activities, such as life skills development, stress and anger management, anticipatory guidance for youth, parenting programs, recreational or volunteer activities, and cultural enrichment programs. Having a directory of such prevention resources in your community will be a useful adjunct to other service directories you use in your work.

Screening, brief intervention, and referral to treatment

SAMHSA has endorsed the use of SBIRT, which integrates initial screening with brief interventions or referral to treatment in some settings with people who may have problems with substance use—including clients with substance use disorders and co-occurring mental disorders. SBIRT is particularly useful with individuals who are homeless in that it requires relatively little time (roughly 5 minutes to screen a patient and 10 minutes to provide a brief intervention) and can prevent the need for further, more intensive services later on (Bernstein et al., 2009).

In 2009, the National Institute on Drug Abuse released an Internet-based, interactive tool for screening and brief intervention to address use of illicit substances. Research supports the efficacy of SBIRT in reducing heavy use of alcohol and illicit drug use across a range of settings and clients. One evaluation of SAMHSA's SBIRT service program found that SBIRT interventions had a positive impact on homelessness as well, with significantly fewer patients reporting lack of housing 6 months after the intervention than had reported it at baseline (Madras et al., 2009).

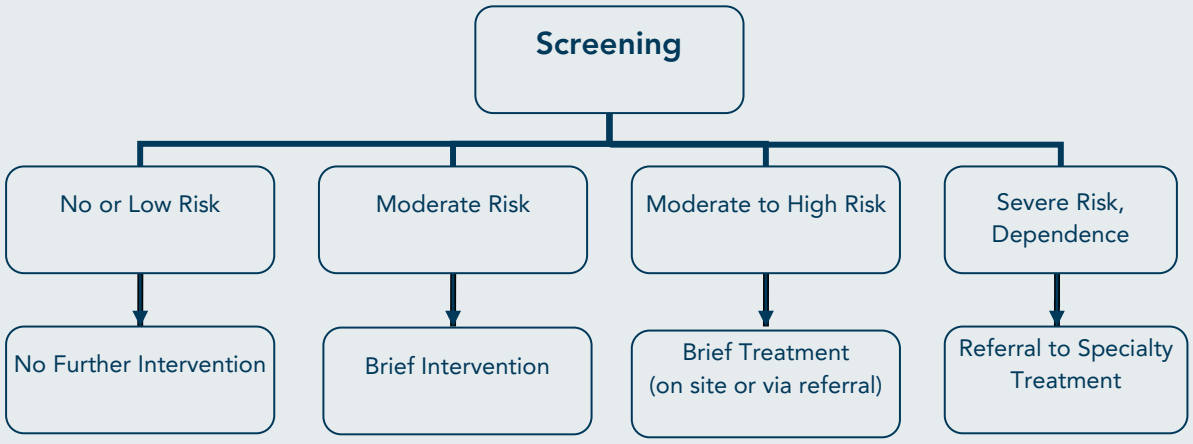
SAMHSA's SBIRT model provides for early intervention and treatment services on a continuum of substance use. Beyond providing for substance abuse treatment, SBIRT also targets nondependent substance use problems and provides effective strategies for early intervention before the need develops for more extensive or specialized treatment. See SAMHSA's planned Technical Assistance Publication, *Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment*, for more information (SAMHSA, planned g).

Early Interventions and Stabilization

As behavioral health service providers further develop and maintain trusting relationships, they engage in intensive early intervention and stabilization while addressing urgent environmental needs (such as health or criminal justice issues) and managing acute substance abuse and mental health symptoms. In both treatment and prevention, this activity involves constructing a treatment and/or prevention plan that is person centered, adhering to an individual's goals. Some people who are homeless will need detoxification as part of a stabilization process. Others may need brief hospitalization to stabilize acute symptoms. Stabilizing is a process of beginning to restore physical health and feelings of safety, to relieve emotional turmoil, and to get a sense of future goals and needs.

Stabilization is a prerequisite for beginning an ongoing recovery program. Yet, for some peo-

How Does SBIRT Work?



Screening (S) is a process of identifying clients with possible substance abuse problems and determining the appropriate course of future action for these individuals. The screening process does not identify exactly what kind of problem the person might have or how serious it might be; it simply determines whether a problem exists and, if so, whether further assessment is needed.

Brief intervention (BI) is appropriate for clients identified through screening to be at moderate risk for substance use problems. BI can be provided through a single session or multiple sessions of motivational interventions. These interventions focus on increasing a client's insight into and awareness about substance use and behavioral change.

Brief treatment (BT), also called brief intensive intervention, is a specialty outpatient treatment modality—a systematic, focused process that relies on assessment, client engagement, and implementation of change strategies. The treatment consists of assessment and a limited number (typically 6 to 20) of evidence-based, highly focused, and structured clinical sessions (e.g., solution-focused therapy, cognitive–behavioral therapy). Clients may receive BT on site but more commonly are referred to an outside program or another component of a medical system.

Clients identified as needing BT or more intensive treatment are referred to specialty substance abuse treatment (**referral to treatment** [RT]), the primary goals of which are to identify an appropriate treatment program and to facilitate the individual's engagement. RT requires a proactive, collaborative effort between SBIRT providers and those providing specialty treatment to ensure that, once referred, the client accesses and engages in the appropriate level of care.

Source: SAMHSA, planned g.

ple—particularly those who have been living in ambiguity, chaos, or from crisis to crisis—stabilization can be uncomfortable. Some might describe their experience as "waiting for the other shoe to drop." Others may have a well-developed ability to "look good" despite physical, emotional, interpersonal, and environmental instability. It is important for you to assess carefully the rate and extent to which a person has actually begun to stabilize; you must resist the temptation to push ahead before stabilization is established. This accentuates how the activities of stabilization may often challenge engagement, in that careful and active worker–client collaboration is required.

Treatment and Prevention Planning

Treatment and prevention planning needs to be person-centered, addressing the client's goals and using agreed-upon strategies. Planning should include decisions about:

- Which services the person needs and wants.
- Where the services will be provided.
- Who will share responsibility with the individual for monitoring progress.
- How services will be coordinated and reimbursed.

Developing treatment and prevention plans for clients with complex needs is, at best, difficult. Services have to be prioritized and plans made based on outcomes that have not yet been achieved. Both treatment and prevention are likely to involve multiple programs, each with its own goals and priorities, rules, and restrictions, and with different levels of involvement with the client or program participant. For instance, some services require a one-time visit (such as obtaining identification or screening for substance-related and mental health issues), whereas others—such as management of chronic health conditions—may be ongoing. Given this degree of complexity, treatment plans should include:

- Specific biopsychosocial goals relevant to the individual and his or her living situation.
- Projected timeframes for accomplishing these goals.
- Appropriate treatment and prevention approaches.
- Housing and services the client will need during service delivery.
- Follow-up activities during ongoing rehabilitation.

Some services may have priority over others by virtue of immediacy of need or other constraints. For many people who are homeless, life stabilization and safe housing are requisites for approaching and establishing recovery from substance abuse or mental illness. For others, achieving some treatment goals (such as abstinence) may diminish the intensity or importance of other problems. Most important, treatment and prevention planning needs to consider the whole person and to prioritize clients' immediate and longer-term goals. Planning should consider the environment in which clients live, differentiate between the problems that can be resolved and those that can only be lessened, and set priorities for services.

Case Management

Case management, which is often assertive in the beginning of care for people in homelessness rehabilitation, is essential in addressing clients' manifold needs and preventing clients from becoming lost in the maze of community services. The job of case management will generally fall to a counselor in a treatment agency, but there is no reason why a properly trained preventionist cannot serve as a case manager. Although most behavioral health counselors are well trained in case management processes and techniques, clients who are homeless have unique needs and may require assistance with such tasks as arranging transportation, obtaining appropriate clothing for interviews, ensuring follow-through on referrals, understanding the instructions provided by other agencies, and assembling appropriate information and credentials needed by other community programs. Particularly in work with people who are homeless, case management services need to begin when the client enters the service system so that needs are anticipated, clients are not overwhelmed with numerous referrals at once, and you and your clients have time to prepare for upcoming referrals.

Preventive services using case management methods

Although traditionally associated with health, mental health, or substance abuse treatment services, case management extends to preventive services as well. Indeed, the same concerns that motivate case management in treatment services (e.g., matching services to needs, locating appropriate providers, supporting participation in and compliance with collaborative treatment planning, assisting with logistics such as transportation and child care, monitoring attendance and progress) apply as much to preventive services.

The same person may serve as a treatment and prevention case manager, or the prevention case management function may be fulfilled by a prevention professional collaborating with the treatment case manager. In either case, the goal is to integrate treatment and prevention services to meet the unique needs and personal goals of the service recipient.

This TIP emphasizes that people who are homeless or at risk of homelessness can benefit from a variety of preventive services, especially clinical preventive services (i.e., selective and indicated prevention; see Exhibit 1-1). The TIP has discussed a variety of preventive services, including screening and brief or early intervention for emerging substance use or mental disorders, skill building (e.g., parenting skills, coping skills, anger management), strengthening families, relaxation training, exercise, recreation programs, and community involvement. These are illustrated in Vignettes 4 (Troy) and 6 (Mikki) in Part 1, Chapter 2. Such services may be offered by local governments, schools and community colleges, freestanding prevention agencies, social service agencies, primary care providers, organizations that serve aging individuals, community clinics, Boys & Girls Clubs, YMCAs, YWCAs, fraternal organizations, congregations, community coalitions, and so on. Not all communities offer all these services. Prevention case managers should develop a comprehensive prevention directory for use in matching client needs to available services.

The principles and procedures presented in this chapter apply to prevention-related case management as much as to treatment-related case management. The only difference is that the prevention case manager will likely need to access a wider variety of community agencies to meet preventive service needs.

Retaining Clients in Treatment and Maintaining Continuity of Care

For clients who have been living with chronic crises of housing, health care, drug use, criminal justice constraints, financial needs, and perhaps other issues, providing comprehensive, integrated care can seem an impossible task. As a result, it becomes important to keep treatment and prevention goals realistic and achievable, relatively short term (although you and the client may have long-term goals in mind), and measurable. Specific strategies to improve retention may be desirable, such as rewards for achieving and maintaining drug abstinence or consistent participation in treatment or prevention activities.

Defining a process for the setting of goals can be beneficial. You should collaborate with clients to set goals in accordance with their priorities. Targeted goal management will allow you to work with clients to assess current and evolving needs for financial benefits and health insurance; substance abuse, psychological, and medical treatment and prevention services; housing resources; access to transportation; employment and education; social supports; assistance with legal problems; and recreational activities.

As people identify their most important, pressing goals, collaboratively identify one activity related to each goal area that:

- Is specific (e.g., number of weekly negative urine samples screened, groups attended, parenting sessions completed, volunteer opportunities identified, or job applications completed).
- Can be completed successfully in a given timeframe.
- Can be verified objectively via receipts, agency reports, worksheets, or the like.
- Is tailored to the client's individual level of psychosocial functioning and personal and social resources to increase the likelihood of successful completion.

Small successes and progress toward personally meaningful goals while maintaining accountability and autonomy build client self-esteem and confidence. Your relationship with the people you serve is strengthened through collaborative decisionmaking about activities to be accomplished and reinforcing the individual's completion of activities. In traditional treatment programs, reinforcement for completing activities includes social recognition and sponsor status in mutual support groups, take-home privileges, early dosing windows in methadone maintenance programs, and vouchers for self-care items and food. In prevention programs, reinforcement may take the form of social recognition, opportunities for training, or attendance at conferences.

Relapse Prevention and Recovery Management

Clients with mental illnesses, substance use disorders, cognitive impairment, and/or family histories of substance use and mental disorders are at higher risk for relapse and subsequent loss of housing (see the planned TIP, *Recovery in Behavioral Health Services* [SAMHSA, planned e]). As individuals move into the clinical stage of ongoing rehabilitation, a variety of evidence-based and best practices interventions are available to support personal recovery, including relapse prevention and wellness self-management.

Wellness self-management, also termed illness self-management, is a manualized, evidence-based, time-limited group technique that helps teach skills of maintaining and enhancing health and wellness (Mueser et al., 2006). Interventions are typically delivered through a series of classroomlike group sessions that capitalize on cognitive–behavioral techniques, each focusing on a wellness topic, such as medication compliance, diet, or stress management. Simultaneously, mental health and substance use issues undergo continuing treatment, along with housing supports. Supportive housing that accepts and addresses relapse or recurrence of psychiatric symptoms aids this. Coping skills training, employment and educational assistance, and the encouragement of establishing social connectedness through participating in other community institutions (e.g., faith-based organizations, senior centers, community volunteer groups, recreational groups), as well as recovering family ties, help maintain the personal recovery process (Marlatt & Donovan, 2005).

Evidence-Based Practices in Homelessness Rehabilitation

Exhibit 1-6 presents promising and evidence-based practices that support people who are homeless while they move through the stages of rehabilitation and establish stable housing and long-term recovery. You may already use these practices in the behavioral health treatment settings in which you work.

Several evidence-based practices have been evaluated specifically with homeless populations, including ACT, critical time intervention (CTI), motivational interviewing (MI), contingency management, cognitive–behavioral

Exhibit 1-6: Promising and Evidence-Based Practices by Rehabilitation Stage

Treatment Approach		Engagement	Transition	Intensive Care	Transition	Ongoing Rehabilitation
Incentives (food, transportation, benefits)		X	X	X	X	
Primary medical care		X	X	X	X	X
Motivational interviewing		X	X	X	X	X
Clinical preventive services	Indicated (e.g., screening, brief intervention)		X	X	X	X
	Selective (e.g., skills development, anger management, anticipatory guidance, parenting programs)		X	X	X	X
	Universal prevention programs (e.g., workplace programs, recreation programs, volunteerism)	X	X	X	X	X
Integrated treatment for CODs		X	X	X	X	X
Peer support		X	X	X	X	X
Family and social support		X	X	X	X	X
Intensive case management		X	X	X	X	
Critical time intervention			X		X	
Contingency management			X	X	X	
Assertive community treatment		X	X	X		
Illness self-management					X	X
Medication			X	X	X	X
Cognitive–behavioral interventions				X	X	X
Relapse prevention				X	X	X
Supportive housing		X	X	X	X	X
Supportive employment (e.g., the International Center for Clubhouse Development model)					X	X

interventions, supportive housing, and supportive employment. ACT is a widely used treatment method adapted from services for people with chronic mental illness for work with people who are homelessness. Numerous studies (e.g., King et al., 2009; Nelson, Aubry, & Lafrance, 2007) have shown that the intensive services provided by ACT teams increase treatment adherence, reduce days of hospitalization, and increase housing stability. Teams composed of mental health professionals provide a wide variety of services, including case management, mental health services, crisis intervention, treatment, education, and employment support. ACT services are available around the clock to respond to the client's immediate needs. ACT has been widely implemented in a number of countries, including the United States. For more information on ACT, visit the ACT Association Web site (http://www.actassociation.org).

CTI is a time-limited adaptation of intensive case management to bring problem-solving resources, community advocacy, and motivational enhancement to clients who are homeless. It is particularly useful in work with clients who are in transition, such as those entering homeless shelters from prison, and in the development of continuity of care for

people with CODs who are leaving shelters for other community housing resources (Draine & Herman, 2007; Herman, Conover, Felix, Nakagawa, & Mills, 2007; Jones et al., 2003). New York Presbyterian Hospital and Columbia University (2011) developed *The Critical Time Intervention Training Manual,* which describes the phases of the 9-month program of care in CTI as follows:

- Phase One—Transition to Community. A treatment plan is made; clients are linked to appropriate community resources.
- Phase Two—Try Out. Linkages in the system are tested; the treatment plan is formalized, adjusted, and implemented.
- Phase Three—Transfer of Care. Long-term community linkages are monitored and long-term goals are established; work toward them is begun.

Contingency management uses tangible rewards for housing, work training, and work opportunities and can provide direct monetary reinforcement (e.g., gift cards) for accomplishing clearly defined weekly rehabilitation goals. These procedures have been studied intensively in a community setting in Birmingham, AL, in a series of four randomized, controlled trials that showed significant improvement in sustained abstinence, housing stability, and stable employment (Milby et al., 1996, 2000, 2005, 2008).

Cognitive–behavioral interventions have shown clear treatment advantages and sustained superior outcomes for abstinence from 6 to 12 months and from 12 to 18 months after follow-up compared with contingency management alone in a delayed treatment effect. Additional cognitive–behavioral interventions were added to and compared with contingency management alone (Milby et al., 2008).

MI is a client engagement, motivational enhancement, and counseling process that has been widely used in mental health and substance abuse treatment settings and has been adapted for the needs of clients in homelessness rehabilitation. It is particularly efficacious in work with clients who are homeless, abuse substances, and are entering sober housing (Fisk, Sells, & Rowe, 2007). Many standard MI techniques and protocols for enhancing commitment to treatment and reducing resistance are applicable to clients experiencing homelessness. For more information on MI protocols, see TIP 35 (CSAT, 1999b).

Supportive housing can improve sustained abstinence, stable housing, and employment (Milby, Schumacher, Wallace, Freedman, & Vuchinich, 2005), and it can greatly improve housing stability for clients with serious mental illness who are homeless (Tsemberis, Gulcur, & Nakae, 2004).

Supportive employment assists clients in accessing, obtaining, and maintaining employment as a primary method to prevent or end homelessness. Recognizing work as a priority in preventing or ending homelessness, Shaheen and Rio (2007) note that early treatment and rehabilitation efforts often focus more on housing and supportive services and highlight the value of assisting clients in obtaining employment and/or education early in rehabilitation. They suggest that employment helps clients who are experiencing homelessness develop trust, motivation, and hope. Supportive employment not only helps people find jobs; it also helps them achieve continued employment by teaching them skills such as problem-solving, managing interpersonal conflicts, developing appropriate work-related behaviors, and managing money wisely.

Your knowledge and skills in working with clients who have mental and substance use disorders may be particularly important in helping them maintain abstinence, regulate symptoms, maintain motivation, and

strengthen the interpersonal skills that are necessary to maintain employment and pursue education. Many individuals who have not been employed for months or years—clients who are just leaving prison or are chronically mentally ill—may first need a supervised work environment to develop or improve these skills. The VA hospital system has used a variation of supportive employment called individual placement and support (IPS). IPS focuses on rapid placement in jobs of the clients' choosing, competitive employment, ongoing and time-unlimited support, integrated vocational assistance and clinical care, and openness to all who want to work, regardless of clinical status or work experience (Rosenheck & Mares, 2007).

There are dozens of universal, selective, and indicated evidence-based prevention programs applicable to populations of people who are homeless, but few have been specifically tested with these populations. SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) lists two evidence-based prevention programs for youth that address substance abuse and mental health outcomes.

The Curriculum-Based Support Group (CBSG) Program (Arocena, 2006) is a support group intervention designed to increase resiliency and reduce risk factors among children and youth ages 4 through 15 who are identified by school counselors and faculty as being at elevated risk for early substance use and future delinquency and violence (e.g., they are living in adverse family situations, displaying observable gaps in coping and social skills, or displaying early indicators of antisocial attitudes and behaviors). Based on cognitive–behavioral and competence-enhancement models of prevention, the CBSG Program teaches essential life skills and offers emotional support to help children and youth cope with difficult family situations; resist peer pressure; set and achieve goals; refuse alcohol, tobacco, and drugs; and reduce antisocial attitudes and rebellious behavior.

Lions Quest Skills for Adolescence is a multicomponent, comprehensive life skills education program designed for schoolwide and classroom implementation in grades 6 through 8 (ages 10–14). The goals of the Lions Quest program are to help young people develop positive commitments to their families, schools, peers, and communities and to encourage healthy, drug-free lives. (See SAMHSA's NREPP for further information at http://nrepp.samhsa.gov.)

Say it Straight (Englander-Golden et al., 1996) is a communication training program that helps students and adults develop empowering communication skills and behaviors and increase self-awareness, self-efficacy, and personal and social responsibility. In turn, the program reduces risky or destructive behaviors (e.g., substance use, eating disorders, bullying, violence, precocious sexual behavior, behaviors that can result in HIV infection).

One area of mental health promotion/mental illness prevention that has been addressed in some literature is suicide prevention. People who are homeless have high rates of suicidal ideation and suicide attempts. Childhood homelessness, being homeless for 6 months or more, and substance use disorders in adults ages 55 and older are all associated with greater rates of suicidality (Prigerson, Desai, Mares, & Rosenheck, 2003). More information on suicide prevention for clients in substance abuse treatment can be found in TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a).

Additionally, a variety of evidence-based practices noted in NREPP, although not tested specifically with populations of people who are homeless, have significant implications for

The Clubhouse Model of Transitional Employment

NREPP lists the International Center for Clubhouse Development's (ICCD's) clubhouse model as an evidence-based program. A clubhouse is a day program, often run at a community center, that supports people recovering from mental illness by helping them rejoin the job force and fostering stronger friendships, family relationships, and educational aspirations. Clubhouses are built on:

- *A work-ordered day.* The daily activity of a clubhouse is organized around a structured system known as the work-ordered day. The work-ordered day includes an 8-hour period that parallels typical business hours. During this period, members and staff work together to perform important tasks in their communities. There are no clinical therapies or treatment-oriented programs in the clubhouse; members volunteer to participate as they feel ready and according to their individual interests.
- *Employment programs.* Clubhouses provide members with opportunities to return to paid employment in integrated work settings. These opportunities include transitional employment—a highly structured means for gaining work in local business and industry. Members receive part-time placements (15–20 hours per week) along with onsite and offsite support from clubhouse staff and members. Placements generally last 6 to 9 months, after which members can seek another transitional placement or move on to independent employment. Transitional employment allows mentally ill individuals to gain the skills and confidence necessary for employment while they hold a real-world job.
- *Evening, weekend, and holiday activities.* Clubhouses provide both structured and unstructured social/recreational programming outside the work-ordered day.
- *Community support.* People with mental illness often require a variety of social and medical services. Through the work-ordered day, members receive help accessing the best quality services in their community, acquiring and keeping affordable and dignified housing, receiving psychiatric and medical services, getting government disability benefits, and so forth.
- *Outreach.* Clubhouse staff maintain contact with all active members. If a member is hospitalized or does not attend the clubhouse, a telephone call or visit serves to remind that member that he or she is missed, welcomed, and needed at the clubhouse.
- *Education.* Clubhouses offer educational opportunities for members to complete or start certificate and degree programs at academic and adult education institutions. Members and staff also provide educational opportunities within the clubhouse, particularly in areas related to literacy.
- *Housing.* A clubhouse helps members access safe, decent, dignified housing. If there is none available, the clubhouse seeks funding and creates its own housing program.
- *Decisionmaking and governance.* Members and staff meet in open forums to discuss policy issues and future planning. An independent board oversees management, fundraising, public relations, and the development of employment opportunities for members.

The ICCD Web site (http://iccd.org/) offers a directory of clubhouses and more information on this transitional employment model. TIP 38, *Integrating Substance Abuse Treatment and Vocational Services*, covers employment services and can help you select employment support models suitable for clients who are homeless and have behavioral health issues (CSAT, 2000a). SAMHSA's *Supported Employment Evidence-Based Practices (EBP) KIT* (SAMHSA, 2009) provides practice principles for supported employment, an approach to vocational rehabilitation for people with serious mental illness. It promotes the belief that everyone with SMI is capable of working competitively in the community. The KIT is available for free at SAMHSA's Publications Ordering Web page (http://store.samhsa.gov).

Source: International Center for Clubhouse Development, 2009. Adapted with permission. See also Schonebaum, Boyd, & Dudek, 2006; Macias, Rodican, Hargreaves, Jones, Barreira, & Wang, 2006.

work with this population. Three examples of tested programs for trauma treatment include Seeking Safety, Trauma Recovery and Empowerment Model (TREM), and a modification of TREM, The Boston Consortium Model: Trauma-Informed Substance Abuse Treatment for Women. All of these programs use cognitive–behavioral and psychoeducational methods to teach problem-solving, coping skills, and affect regulation strategies to individuals who have experienced significant trauma. A program that is particularly relevant to people who are homeless and have co-occurring substance use and mental disorders is Modified Therapeutic Community for Persons With Co-Occurring Disorders, a long-term residential program with the structure and processes of a traditional therapeutic community but with adaptations for individuals with co-occurring disorders. The program can be flexibly applied in both correctional and community settings and includes components on mental health and substance abuse treatment. For more information on these and other evidence-based programs, refer to the NREPP Web site (http://nrepp.samhsa.gov/).

Special Issues in Service Delivery

People with substance use and/or mental disorders who are homeless have a variety of specific needs and considerations in treatment and prevention programs. These needs tend to fall into three major categories:

- Specific client needs
- Family services to reduce the risk of intergenerational problems
- Cultural competence

Specific Client Needs

It is unrealistic to expect that people who are experiencing homelessness will be able to maintain housing if their social and health needs are not met. It is also much more difficult for individuals with substance use and mental disorders to manage their symptoms when these basic needs are not met. Some of the most pressing issues of people who are homeless include:

- Addressing acute and chronic medical conditions (e.g., diabetes, HIV infection, heart and respiratory conditions, and the like, as well as drug detoxification and medical stabilization of mental illnesses).
- Having untreated or inadequately treated disabilities, such as hearing and/or vision impairment, lack of balance, or mobility impairments.
- Recognizing cognitive problems, such as memory deficits, poor attention, and concentration.
- Making the transition from jail or prison to the "free world," which includes adapting survival skills that were functional in prison but are counterproductive outside the criminal justice system.
- Making the transition from inpatient hospitalization, where people are free from responsibility for their care, to having to assume full accountability for their care and their behavior.
- Dealing with a history of trauma when sudden or unexpected events may trigger flashbacks or other responses that are perceived as inappropriate and when symptoms of psychological trauma mimic, exaggerate, or obscure the symptoms of other mental and substance use disorders.

Family Services To Reduce the Risk of Intergenerational Problems

Integration of prevention and treatment services for families who are homeless is critical. Family programs involving parents and their children have been a mainstay of universal, selective, and indicated prevention programs

for at least 3 decades. Examples include parent participation (e.g., homework assignments) in school-based programs (universal), home-visit programs for high-risk families (selective), and intensive parent–child interventions when one or both parents are undergoing substance abuse treatment (indicated). All of these programs—particularly those categorized as indicated—are appropriate for families who are homeless in which the parents receive substance abuse or mental illness treatment.

NREPP (http://nrepp.samhsa.gov) lists over 50 family programs that may be relevant to working with families who are homeless. A few examples include:

- The Strengthening Families Program: This is a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children 3–16 years old.
- The Strengthening Families Program for Parents and Youth 10–14: This family skills training intervention is designed to enhance school success and reduce youth substance use and aggression among 10- to 14-year-olds.
- The Clinician-Based Cognitive Psychoeducational Intervention: Intended for families with parents who have a significant mood disorder, this intervention is designed to provide information about mood disorders to parents, equip them with skills they need to communicate this information to their children, and open a dialog in families about the effects of parental depression.
- DARE To Be You: This multilevel prevention program is intended for high-risk families with children 2–5 years old. Program objectives focus on children's developmental attainments and aspects of parenting that contribute to youth resilience to later substance abuse, including parental self-efficacy, effective child rearing, social support, and problem-solving skills.
- Familias Unidas: A family-based intervention for Hispanic families with children ages 12 to 17. The program is designed to prevent conduct disorders; use of illicit drugs, alcohol, and cigarettes; and risky sexual behaviors by improving family functioning.

Cultural Competence

Race, ethnicity, and culture influence how people express problems, seek help, and accept services. Your cultural background and that of your clients can influence how you present services and how acceptable they are to clients. Staff members should reflect the diversity of the population, work in teams that incorporate diversity, and engage in team discussions about the influence of cultural factors on engagement and retention, risk and protective factors, and resiliency (Rowe, Hoge, & Fisk, 1996). It may be important to include service providers on your team who have experienced homelessness themselves and understand that homelessness itself can be part of a subculture with its own expectations, behaviors, and patterns of communication; understanding this culture is essential to effective work with individuals and families who are homeless.

Culturally competent service providers understand that people sometimes reject services because of cultural norms and/or past negative experiences with the service system. For example, your organization may find that many clients who are at risk of homelessness live with family members who will not come to your organization for services. A culturally responsive service strategy may involve a service provider of the same cultural background providing services where the client lives. You can act as a consultant, offering psychoeducation and skills development to address

individuals' issues in a manner that is acceptable to them (Connery & Brekke, 1999).

Culturally competent counselors are also mindful of the client's linguistic requirements and the availability of interpreters. You should be flexible in designing a treatment plan to meet client needs, and, when appropriate, you should draw upon the institutions and resources of your client's cultural community. Treatment providers need to plan for the provision of linguistically appropriate services beginning with actively recruiting bicultural and bilingual clinical staff, establishing translation services and contracts, and developing treatment materials prior to client contact. Even though you cannot anticipate the language needs of all potential clients, you *can* develop a list of available resources and program procedures that can be followed when language needs fall outside the treatment program's typical client demographics.

Women often have unique experiences and challenges different from the male majorities usually found in substance abuse treatment. They often find or take few opportunities to talk in male-dominated groups about physical or sexual abuse perpetrated by the men in their lives, perceived barriers to restoring child custody, and other women's issues. Absence of opportunities to discuss gender-related problems usually precludes the development of a comprehensive rehabilitation plan to address them (CSAT, 2009d).

People who are lesbian, gay, bisexual, or transgendered may face different barriers to services. People who are transgendered may need special consideration of options and advocacy prior to placement in shelters, treatment centers, prevention programs, and housing.

For more information on culturally competent behavioral health treatment, see the planned TIPs, *Improving Cultural Competence* (SAMHSA, planned c) and *Behavioral Health Services for American Indians and Alaska Natives* (SAMHSA, planned a), as well as *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT, 2001).

Community Housing Services for People Who Are Homeless

Unless you work in a setting specifically designed to serve people who are homeless, you are probably not acquainted with the variety of homelessness services available in your community. Services can vary widely from one community to another based on community needs and program goals. You may also not be aware of abstinence or other specific requirements among different program and housing options. Housing services also exist for special populations that might be important in your work, such as veterans or people who live in rural areas. Additionally, the services clients need will vary by the type of homelessness they are experiencing.

In general, housing services can be divided into four main categories.

Emergency shelters provide brief-stay, overnight accommodation to people who have no safe place to stay for a short period of time. Often, people cannot enter the shelter until the late afternoon and must leave by a specific time the next morning. Most allow for storage of personal possessions during the day while the individual has to be out of the shelter; some require that all possessions be taken by the occupant when they leave each day. Most shelters offer assistance with food and other emergency needs, but given their short-term focus, do not provide ongoing services for residents.

Temporary housing can be provided in a variety of settings, including shelter settings (such as a shelter specifically for persons affected by domestic violence), multiple-occupancy dwellings, hotels and single-room occupancy (SRO) settings, small clustered apartments, or apartments in the community. Temporary housing is often a resource for families and individuals in crisis who need immediate housing help and assistance with social service, health, mental health, substance use, financial, legal/criminal justice, and other needs. Temporary housing services typically provide outreach and engagement, case management, referral, and follow-up services to mitigate or resolve crises. Temporary housing services are generally limited to 2 or 3 months' duration. After stabilization, individuals and families may move to either transitional or permanent supportive housing.

Transitional housing is useful for individuals who have no permanent place to live and are making a transition from a location where they have been temporarily housed (temporary housing, a substance abuse or mental health treatment facility, a criminal justice setting, etc.) to housing that supports their transition to a more permanent setting. Transitional housing is normally provided for periods of a few months to 2 or 3 years and is accompanied by a variety of resources (social services, health care, employment assistance, mental health and substance abuse treatment, case management, and other services). The use of transitional housing supports for people who have been in substance abuse and/or mental health treatment to smooth reentry into the community is discussed in Part 1, Chapter 2, of this TIP (see the vignette about Sammy). Transitional housing and accompanying supportive services are funded by a variety of resources.

Permanent supportive housing combines a long-term commitment to affordable housing with supportive services to allow individuals and families to live more productive and stable lives; it is a primary thrust of SAMHSA's (along with other Federal agencies') efforts to address the needs of people with disabilities. Typically, permanent supportive housing provides homes for individuals and families who otherwise would be living with the constant threat of homelessness and would lack the supportive social and health services (such as primary health care, mental health treatment, employment, and economic and other resources) necessary to adequately cope in the community. There are no requirements that individuals in permanent supportive housing obtain mental health or substance abuse treatment, and there are no requirements about abstinence from alcohol and/or drugs as a condition for participation in the program. Supportive housing can, however, be coupled with such social services as job training, life skills training, and alcohol, drug abuse, and mental health treatment.

Case management is a key element in helping individuals and families in permanent supportive housing obtain the care they need. Permanent supportive housing can be an apartment or SRO in a building that houses individuals who were formerly homeless, special-needs housing in the same building with generally affordable housing, a rent-subsidized apartment in the open housing market, designated units within privately owned buildings, or individual single-family homes.

Examples of populations served by permanent supportive housing are adolescents, the elderly, persons with serious mental illness, people who are developmentally disabled, and people moving out of transitional or temporary housing who still lack the resources to live in the community without housing assistance. Permanent supportive housing has been shown to be economically viable by creating safe and

stable environments in which individuals and families can regain employment, reduce social service and healthcare costs, and reduce costs related to dependence on more expensive housing options. As with transitional housing, permanent supportive housing is supported by HUD, SAMHSA, other Federal resources, State and community resources, and direct payment from those receiving services.

SAMHSA's Homelessness Resource Center (http://homeless.samhsa.gov/) offers resources on community housing services for individuals and families who are homeless or threatened with homelessness. Their efforts include the *Permanent Supportive Housing Evidence-Based Practices (EBP) KIT* (SAMHSA, 2010), a series of eight booklets on developing permanent supportive housing programs using evidence-based practices.

What the Behavioral Health Service Provider Should Know

Your community may offer a variety of housing options to behavioral health clients who are homeless or are at high risk for homelessness. Some of these options are for emergencies only or are short term, whereas others are ongoing. Some have special restrictions, such as serving only persons with a major mental illness or requiring participation in programs to build employment, money management, and daily living skills. Some programs that primarily serve clients with substance use disorders have rules about drug use either in the residence or while a client is in the program. However, the permanent supportive housing approach, a major focus of Federal housing assistance today, does not mandate mental health, substance abuse, or other care or social services as a condition of participation.

One of your jobs is to become familiar with the resources in your community. You will want to build linkages with these organizations and with their staff members to learn what range of services they provide. This will allow you to recommend particular clients to these organizations in accordance with their specific needs. What are the requirements for accessing their services? What types of reimbursement do they accept? You may be aware of gaps in the services available in your community. Collaborative efforts can, in some cases, help obtain funding, staff, and facilities to fill these gaps. Part 2 of this TIP discusses "bottom-up planning," in which treatment staff identify a service need and programs evolve in response to it. Bottom-up planning should always involve program administration, direct service personnel, clients, and other community resources.

Knowing how to assess your clients' needs is also part of your job. Do they need substance abuse and/or mental health services? Are they ready to accept such services? From what types of medical services and financial help would they benefit? Are they self-sufficient? Do family members need prevention services? Do they require special services to address physical or other disabilities? Are their housing needs chronic and long term or transitional and short term?

Along with these questions, you will want to consider the issue of how best to present a program's goals and rules to clients so as to encourage them to take advantage of community resources. They may need to accept restrictions on their behavior in exchange for shelter. Some negotiation may be necessary to help the client see the advantages of receiving services while consenting to a program's boundaries.

Housing Services for Individuals With Substance Use and/or Mental Disorders

Housing services for people with a substance use disorder and/or a mental illness can be divided into two broad categories: (1) housing specifically provided for clients in early and ongoing recovery from substance use and mental disorders, and (2) housing that offers a safe place to live, a variety of options for homelessness rehabilitation, and other social, health, and behavioral health services. Sometimes, these programs will offer behavioral health treatment and prevention services primarily directed toward the precontemplation and contemplation phases of treatment.

Some communities may offer homelessness and behavioral health treatment services that overlap with these two housing options. Additionally, other shelter or housing options in your community may simply offer temporary housing with no additional social, physical health, or behavioral health services. Because most communities have few, if any, prevention services specifically designed for persons who are homeless, training for prevention workers in the special needs of homeless populations may broaden the range of preventive interventions available to these populations.

Clearly, there is no "one size fits all" accommodation for the diverse population of people with substance use disorders and/or mental illness who are also faced with homelessness. For example, people who are in crisis and transitionally homeless need different services from those who are chronically homeless. Programs for persons with mental or substance use disorders may need to work in close coordination with homelessness programs, especially in early recovery.

Housing services focused on supporting recovery from substance abuse and mental illness

In your work, you will encounter individuals who either are homeless when they enter your program or become homeless during program participation. Some people who are homeless enter programs, especially treatment programs, because they perceive that they have no other place to go. Others—including persons coming from the criminal justice system—may have had stable housing (jail or prison) but have not considered where to live after being released. Some lose their jobs before or during program participation and are left with no housing options. Others may have family members who refuse to allow them to return until they have achieved substantial sobriety, significant stabilization of their psychological symptoms, or significant improvement in interpersonal skills. In any case, homelessness or the threat of it represents a substantial crisis that destabilizes people and challenges their ability to maintain recovery and other gains.

Homelessness also represents a significant case management problem for mental health and substance abuse treatment staff members who are concerned with finding housing resources. Some considerations that have to be addressed include limited resources for housing people in early recovery from substance abuse and/or mental illness in the community, the time required to find and evaluate potential resources, the collaboration efforts involved in working with other community agencies, and the limited funding available for housing services appropriate for people in early recovery. In addition to addressing these considerations, you will need to ensure that individuals who are homeless can continue to participate in services and continuing care. You will need to work with them to manage transportation, mental health, healthcare, financial, criminal

justice, and employment issues that are complicated by homelessness. The reality is that an individual who is homeless is in crisis and has housing needs that must be addressed in a very limited period of time.

Some frontline resources often used to help individuals who are homeless make the transition to more stable recovery are residential recovery and other housing options that have a primary focus on recovery from substance abuse and mental illness. Generally, these resources fall into four categories: halfway houses, ¾-way houses, sober living residences for clients with substance use disorders, and supportive housing for clients transitioning out of intensive mental health treatment or treatment for co-occurring disorders. With perhaps a few exceptions for clients from the criminal justice system, all clients in these residences enter and remain voluntarily.

Halfway houses with a primary focus on substance abuse or mental illness recovery generally offer more intensive treatment than other recovery housing options, have the most structured programs, and are the most likely to be professionally staffed. They also generally are the most time-limited service (usually 30–60 days). Persons are likely to enter a halfway house on completion of intensive treatment. In a halfway house, residents are expected to participate in regularly scheduled (usually daily) individual and group treatment, and regular attendance at 12-Step or other self-help and recovery programs is either mandated or actively encouraged. Program rules often limit the amount of time residents can spend away from the house and the contacts they can have in the community. Programs also specify meal and sleeping times, provide medication management, and usually have an active focus on relapse prevention and recovery maintenance. Case management services, provided by counselors or specialized case management staff, are often available. Frequently, supportive services, such as employment assistance, health care, and financial assistance, are available to residents either "in house" or through referral.

Generally, **¾-way houses** have fewer staff persons with professional credentials and may only be staffed by a house manager and assistants. Residents have more autonomy in managing their time and community contacts, and (unless employment is not a consideration for the client) they are usually employed, expected to be seeking employment, or in a job training and support program. Significantly less treatment by professionals is offered in ¾-way houses than in halfway house programs. Residents are expected to maintain abstinence, monitor psychological symptoms, and manage their medication with the support of staff; are often expected to participate in continuing care and 12-Step recovery programs; and may be encouraged (after some time in the house) to seek other residential options. Clients may have the option of staying in a ¾-way house for a longer period than in a halfway house.

In recent years, a variety of **sober living housing** options have emerged for people in recovery from substance use disorders and fill a critical need for housing for people in recovery who do not need more intensive residential services. The best known sober living facilities today are Oxford Houses (http://www.oxfordhouse.org). The Oxford House movement has residential facilities throughout the United States that are drug free, self-supporting, and democratically governed by the residents and a board of directors. They normally have 8 to 15 residents. Complete abstinence from alcohol and illegal or illicit drugs is a requisite for residence. Residents can live in the house as long as they desire. There is no professional staff and there are no requirements about attending treatment. Participation in 12-Step programs is

strongly encouraged. Other sober living houses that are not affiliated with Oxford Houses may also be available in your community.

Community transitional **supportive housing** can be an intermediate step between leaving an inpatient facility for substance abuse and/or mental health treatment and living independently in the community. Supportive housing programs for people leaving intensive treatment ordinarily provide an affordable place to live; close links to treatment; support in medication maintenance; services to develop and enhance skills in household, job, and financial management; and day-to-day support from professional and paraprofessional staff. Supportive housing reduces isolation, reduces relapse rates, offers early intervention so that living problems do not escalate, and provides safe housing for people at a very vulnerable point in their lives.

Housing services focused primarily on safe housing and social services

Substance use-related designations for shelter and housing

Housing and shelter programs are sometimes defined by policies related to substance use on and off the premises. Different types of housing are appropriate for clients in different stages of change for substance use behavior and who are, in turn, ready for varying levels of service intensity. In housing, "wet," "damp," and "dry" refer to these levels of service intensity and a concomitant demand for abstinence. Exhibit 1-7 describes each program type. Although programs are defined by allowed substance use, their services are not restricted to people with substance use disorders.

Sometimes, people are placed in housing when they are in the precontemplation stage of change regarding their substance use or mental health issues. They may show little or no motivation or behavior suggesting that they would even consider addressing their problems. Even so, you may still have several options for working with clients who are in the precontemplation stage, including:

- Providing information about recovery and resources that are available, if and when they do sense a need to do something about their use.
- Building stronger relationships focused on their ability to contact a service provider if they decide to get help for substance use.
- Supporting their efforts to consider or act on changing substance use behavior—for instance, by supporting efforts toward abstinence, even for brief periods.
- Helping individuals develop or improve coping skills for managing life without substances.
- Locating housing in congregate living settings with staff members on site who can provide safety and support.

Concerns, such as drug trafficking on the premises, may be a particular risk factor for some persons attempting to maintain abstinence. Onsite staff persons have a greater opportunity to build relationships by sharing activities and conversation. They can also assess an individual's functioning and engage them in appropriate services.

Services for veterans who are homeless

In addition to services available in the community and local treatment system, veterans who are homeless may be eligible for VA services. Eligibility varies for each of these services. In general, eligibility is least restrictive for entry to VA homelessness programs. Those who have a service-connected disability or VA pension are most likely to access VA services. Nearly every VA hospital has a Health Care for Homeless Veterans (HCHV) Program caseworker who can inform you about local services and eligibility criteria. VA services for

Exhibit 1-7: Housing Designations and Readiness to Change Substance Use

Housing Type	Relevant Stage of Change	Description of Housing and Supportive Services
Wet Housing	Suited to precontemplation or contemplation stages of change	• Permits use of legal substances (i.e., alcohol) on premises. • Meets basic needs for safe shelter; increases client readiness to accept other services. • Staff creates consistent, empathic relationships with clients and addresses behaviors related to substance use (e.g., loud, destructive parties) to help clients recognize how substance use affects their lives, goals, and chances of staying housed. • Residents are engaged in treatment and other services as they are ready.
Damp Housing	Suited to contemplation and preparation stages of change	• Abstinence is recommended but not required; intervention occurs if safety becomes an issue. • Meets basic needs for safe shelter; increases client readiness to accept other services. • Staff createes consistent, empathic relationships with clients and addresses behaviors related to substance use (e.g., loud, destructive parties) to help clients recognize how substance use affects their lives, goals, and chances of staying housed. • Residents are engaged in treatment and other services as they are ready.
Dry or Sober Housing	Suited to action or maintenance stages of change	• Strict abstinence policy—substance use results in termination of housing. • Staffed group homes (i.e., transitional or permanent supportive housing programs) or independent group sober living, like Oxford Houses. Residents pay rent, utilities, and other household expenses.

Source: Hannigan & Wagner, 2003.

veterans who are homeless vary geographically and include the following:

- HCHV: VA outreach workers and case managers help establish eligibility for VA medical services, develop appropriate treatment plans, and screen for community placement.
- Stand Downs: These give veterans who are homeless 1–3 days of safety and security where they can obtain food, shelter, clothing, and other types of assistance, including VA-provided health care, benefits certification, and linkages with other programs.
- Drop-In Centers: These programs are a daytime sanctuary where veterans who are homeless can clean up, wash their clothes, and participate in therapeutic and rehabilitative activities.

Recovery-oriented and rehabilitative treatment programs for veterans who are homeless include:

- Domiciliary Care for Homeless Veterans (DCHV): DCHV provides residential treatment and rehabilitation to veterans who are homeless.
- VA Grant & Per Diem Program: This program subsidizes residential treatment and transitional housing.
- VA-based substance abuse treatment programs: These can be found using the

SAMHSA Treatment Locator (http://findtreatment.samhsa.gov/).

- Supportive Housing: This program provides ongoing case management services to veterans who are homeless. The emphasis is on helping veterans find permanent housing and providing clinical support to keep veterans in permanent housing.
- Veterans Affairs Supportive Housing Program with HUD: This program provides Section 8 voucher program and permanent housing and treatment for veterans who are homeless and have mental and substance use disorders through VA outreach, clinical care, and ongoing case management services.

Homelessness services in rural areas

People who are homeless in rural and remote areas typically live temporarily in campers, cars, abandoned buildings, tent encampments, or with a succession of friends or family in overcrowded, substandard housing (Dempster & Gillig, 2006). As a result, people who are homeless in rural areas are often less visible than those in more urban settings and may not be counted in census or other surveys. Outreach and engagement are different in rural areas than in urban centers, because people who are homeless in rural areas are more difficult to identify. In addition, outreach and engagement activities are successful only if you can refer individuals to services relevant to rehabilitation from homelessness.

Job opportunities, transportation, health and social services, and shelter options tend to be more limited in rural areas. Individuals with mental illness who are homeless and unable to live with family in rural areas may be particularly vulnerable and may migrate to larger population areas to obtain housing and services. In rural areas where the predominant employment is agriculture, migrant workers who are homeless and depend on employer-supplied housing can be particularly vulnerable. Often, the housing offered for temporarily employed migrant workers is substandard and inadequate, creating a unique situation of homelessness or near homelessness.

To create temporary shelter, some providers develop contracts with local property owners in which an agency pays a monthly rate for sleeping rooms used as temporary housing until other arrangements are made. This may be more cost-effective when actual numbers of clients do not warrant larger shelter programs; it gives the individual and the agency flexibility to better prepare for more adequate housing. In some locations, faith-based communities can temporarily house people for brief periods in members' homes, church buildings, or in low-cost motels paid for with money set aside to help those in need.

SAMHSA's PATH program provides formula grants to States, which they can then use for homelessness services in rural areas. The grants can be used for outreach, screening, behavioral health services, case management, and other supports for housing assistance. A primary problem is that, given the actual number of individuals and families needing a specific form of housing among a dispersed, rural population, costs for the construction of congregate housing or shelters can be prohibitive. As a result, developing an adequate supply of rental stock and providing rental subsidies may take on particular importance. There is often a waiting list in rural areas for housing that is available through programs serving people who are homeless.

Where adequate services do not exist, workers in PATH-supported outreach and engagement programs in rural areas often carry sleeping bags, camping gear, and food. Some programs employ former consumers who can establish good rapport with individuals who are homeless. The programs work to create

linkages and good relationships with nearby communities and agencies (Robertson & Myers, 2005). The National Alliance to End Homelessness (2010) emphasizes using naturally occurring support networks in rural areas to provide support to people who are homeless. Involvement of local area leaders and stakeholders promotes an inclusive, collaborative system.

You Can Do It

Working with clients who are homeless or at risk of homelessness certainly increases the complexity of your job. Clients who are facing homelessness have unique personal and environmental dilemmas that require special care and attention. Nevertheless, with some additional knowledge, enhanced skills, and an examination of your own attitudes toward homelessness, ***you can do this work*** effectively. The skills required will simply complement the skills you already have as a treatment or prevention professional. The additional knowledge you need will benefit not only your work with people who are homeless, but also your work with any person who has layered problems. A significant milestone in professional growth is expanding your horizons and capabilities to work with different types of people, some of whom have more complex needs than others.

In the next chapter, you will meet several people who are homeless and in various stages of need, and you will examine how your new and expanded knowledge, skills, and attitudes can be applied in realistic treatment and prevention service situations.

Part 1, Chapter 2

IN THIS CHAPTER

- Introduction
- Vignette 1 Juan
- Vignette 2 Francis
- Vignette 3 Roxanne
- Vignette 4 Troy
- Vignette 5 René
- Vignette 6 Mikki
- Vignette 7 Sammy

Introduction

In this chapter, you will meet several people with behavioral health disorders who are homeless or at risk of homelessness. Each person is introduced in a vignette that demonstrates effective approaches to treatment for people who are in different phases of homelessness rehabilitation (described in Part 1, Chapter 1) and who have a substance use and/or mental disorder. Prevention techniques and methods to reduce the incidence or manifestations of mental illness or substance abuse are also demonstrated.

Skills introduced in the seven vignettes include:

- Building rapport.
- Identifying client strengths, needs, preferences, and resources in housing and other life issues.
- Managing inappropriate behavior, requests, and expectations.
- Providing case management to access and coordinate housing and other services.
- Developing and monitoring treatment and housing goals.
- Assisting clients in improving coping skills.
- Adapting services for people who have cognitive problems.
- Adopting a trauma-informed approach to working with all clients who are homeless.
- Helping clients stay engaged in recovery despite ongoing mental illness/substance abuse symptoms.
- Recognizing the impact of co-occurring disorders (CODs) on recovery from homelessness.
- Helping clients find appropriate housing among the variety of options that may be available.
- Preparing clients to accept the terms of rental agreements and other housing constraints.

Each vignette begins by describing the setting, learning objectives, strategies and techniques, and counselor skills and attitudes specific

to that vignette. A description is given of a client's situation and current symptoms. Counselor–client dialog is provided to facilitate learning, along with a selection of aids that may include:

- **Master clinician notes:** comments from an experienced clinician about the strategies used, possible alternative techniques, and insights into what the client or prospective client may be thinking.
- **How-to notes:** step-by-step information on how to implement a specific intervention.
- **Decision trees:** aids to help you sort options and arrive at the best possible outcome.

The master clinician represents the combined experience of the contributors to this Treatment Improvement Protocol (TIP). Master clinician notes assist behavioral health counselors at all levels: beginners, those with some experience, and master clinicians.

Before using the described techniques, it is your responsibility to determine whether you have sufficient training in the skill set and to ensure that you are practicing within the legal and ethical bounds of your training, certifications, and licenses. It is always helpful to obtain clinical supervision in developing or enhancing clinical skills. For additional information on clinical supervision, see TIP 52, *Clinical Supervision and the Professional Development of the Substance Abuse Counselor* (Center for Substance Abuse Treatment [CSAT], 2009b).

For the convenience of the reader, the TIP refers in the vignettes to "counselor" generally rather than specifically by name. This will make it easier for the reader to track who is speaking at any given point in the vignette. As you are reading, try to imagine yourself through the course of the vignette in the role of the counselor. The seven vignettes are as follows:

- **Vignette 1:** Juan is in the outreach and engagement (O&E) phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for responding to his chronic homelessness.
- **Vignette 2:** Francis is in the outreach and engagement phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for responding to his health and safety concerns.
- **Vignette 3:** Roxanne is in the intensive care phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for preventing homelessness and stabilizing a client who is in the precontemplation stage of substance abuse treatment.
- **Vignette 4:** Troy is in the intensive care phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for preventing homelessness and engaging the client in substance abuse treatment.
- **Vignette 5:** René is in the transition planning/ongoing homelessness rehabilitation phase. This vignette demonstrates approaches and techniques for substance abuse relapse prevention.
- **Vignette 6:** Mikki is in the early intervention stage of homelessness prevention. This vignette demonstrates approaches and techniques for preventing additional trauma to her family because of temporary homelessness.
- **Vignette 7:** Sammy is in the permanent supportive stage of homelessness rehabilitation. This vignette demonstrates approaches and techniques for supporting access to housing for a client with serious mental illness (SMI) through programs partially funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Projects for Assistance in Transition from Homelessness (PATH) program.

Vignette 1—Juan

Overview

Juan is in the outreach and engagement phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for responding to his chronic homelessness.

Juan is in his mid-thirties and is chronically homeless. He is dependent on crack cocaine, drinks alcohol, and occasionally smokes marijuana. He typically sits alone at a soup kitchen table. He knows who the outreach team members are and has walked away in the past when approached.

The outreach team has information about Juan from shelter staff members and other people who are homeless. He is unemployed but has worked in the past. Juan is hypersensitive to being "put down" by others. He is easy to anger, and his anger is often out of proportion to the stimulus. If he feels criticized, he will become sarcastic and will withdraw from interaction with others. He is very suspicious of the motives of others, often expecting that people have an agenda to disrespect him. These limitations have resulted in many losses: jobs, family relationships, apartments, and social supports. He has a history of being banned from shelters as a result of outbursts and fighting. The outreach team members believe that if they form a relationship with Juan and offer him a place to live, they will be able to engage him in treatment.

Substance use is believed to play a significant role in Juan's homelessness, so the member of the team who provides substance abuse counseling will take the lead in engaging him. The counselor's goals for the first visit are to:

- Meet Juan and begin to establish a relationship with him.
- Determine whether or not Juan will engage in a conversation about housing and other services.

Setting

The behavioral health counselor is a member of a community-based, interagency O&E team and works for a mental health and substance abuse treatment organization providing O&E services in collaboration with counselors, case managers, and outreach workers from other organizations. A Housing First program is available to clients through this interagency partnership.

Learning Objectives

- Use rapport-building outreach methods:
  - Accurately identify the client's beliefs and frame of reference.
  - Reflect the client's feelings and message.
  - Demonstrate empathy, respect, and genuineness.
  - Offer concrete assistance.
- Establish an initial plan based on the client's needs and preferences, community resources, and the intervention plan.
- Determine the client's stage of change; respond appropriately to changes in client behavior.

Strategies and Techniques

- Rapport and relationship building with a client who is difficult to reach

- Housing First as an approach to provide safe and stable housing
- Motivational interviewing (MI)

Counselor Skills and Attitudes

- Recognize and address ambivalence and resistance.
- Work as a member of a team to remove barriers to services.
- Emphasize client autonomy and development of skills.
- Show respect for both the client's needs and the organization's services.
- Help the client explore resources and determine which ones he would like to use.

Vignette

Visit 1 (soup kitchen)

The counselor walks to a seat near Juan at the soup kitchen, noticing that Juan watches her from the corner of his eye and appears tense. He sits alone and appears disinterested in the goings-on around him.

COUNSELOR: How's it going?

JUAN: Do you work here?

COUNSELOR: I work for the local outreach and engagement team.

JUAN: You're treating people?

[He talks to her, but his demeanor is aloof and suspicious, and he maintains his distance.]

> **Master Clinician Note:** Building relationships with people who are homeless proceeds at their pace. You can give people opportunities to accept assistance, but it is important that you consistently respect their choices. If someone refuses to talk to you, respectfully leave and plan to show up again with something the client might accept (e.g., coffee, socks, a chance to talk). Building relationships with soup kitchen workers who know the client can help you gather more information and facilitate a meeting.

COUNSELOR: No. I get to go out and spend time with people out here. Do you mind if I sit down? [*Juan nods.*] What do you think of the coffee here?

JUAN: Not too good. Better than nothin'.

COUNSELOR: Better than nothin', that's for sure. The food's okay?

JUAN: Yeah. This is a good place to eat, you know, a meal. What's *your* name?

COUNSELOR: It's Megan. How about yours?

JUAN: I'm Juan.

COUNSELOR: It's nice to meet you. So you've been in the area long?

[Juan says that he's been in town for a while and knows his way around. He's currently staying at a shelter that he doesn't like. The noise keeps him up at night, his things get stolen, and there are too many rules. He says he'd rather camp out, except for the police. The counselor mentions the possibility of housing.]

> **Master Clinician Note:** Nonclinical conversation is an important outreach tool. Social conversation is an icebreaker and helps identify a person's interests and needs. While the counselor talks with Juan, she listens for information that will help her guide him in creating a recovery plan—that is, information that may indicate some of Juan's strengths and limitations, problems related to substance use and homelessness, housing history, goals, values, and so forth.

COUNSELOR: If you were to have your own place, what would that be like for you?

JUAN: Well, that's what I do if I find a building where I can camp out. I make it my own place.

> **Master Clinician Note:** Having clients imagine themselves in a desired situation can help you identify what matters to them and the barriers to their goals. Open questions and reflection encourage Juan to elaborate.

COUNSELOR: You set up house.

JUAN: Right. Right now I don't have an income, so there's no way I can pay the rent or get a place, so I'm just making the best of what I got.

COUNSELOR: It's hard to imagine what it'd be like to move into your own place right now because it's hard to imagine how you'd get it. You don't have any income, and that's a problem.

JUAN: Right.

COUNSELOR: One of the things I do is help people find places to live that they can afford.

JUAN: Are you playing a game? You want me to go to treatment or something like that?

Housing First Models

Housing First approaches have been used to engage people who are chronically homeless and have severe and chronic mental illnesses. The goals of Housing First are to end homelessness and promote client choice, recovery, and community integration. Housing First engages people whom traditional supportive housing providers have been unable to engage by offering immediate access to permanent scatter-site independent apartments in buildings rented from private landlords. Clients have their own lease or sublease and only risk eviction from their apartments for nonpayment of rent, creating unacceptable disturbances to neighbors, or other violations of a standard lease. To prevent evictions, teams work closely with clients and landlords to address potential problems. Refusal to engage in treatment does not precipitate a loss of housing. Relapses to substance abuse or mental health crises are addressed by providing intensive treatment or facilitating admission to detoxification or the hospital to address the clinical crisis. Afterward, clients return to their apartments. Support services are often offered through multidisciplinary assertive community treatment (ACT) teams, with slight modifications.

Source: Stein & Santos, 1998.

COUNSELOR: No, you don't have to go to treatment to get into housing. We have a program called "Housing First" that might really be something you could look into.

JUAN: Well, I don't understand. Why would you do that for me?

COUNSELOR: I think somebody would do that for you if they thought you could do it successfully.

JUAN: My own place—somebody's gonna give me my own place?

COUNSELOR: Doesn't make a lot of sense to you, does it?

JUAN: No; what's the catch?

COUNSELOR: You and I would have to have a plan for how you would hang onto that place.

Master Clinician Note: The counselor demonstrates that the client can expect her to be honest about what to expect. As he considers making a change, it's natural for him to feel ambivalent about it and back off. This is part of the process of engagement, and the counselor doesn't want to prevent his ambivalence from arising. In the following exchange, she'll reflect both sides of his ambivalence so he can see the discrepancy between where he is now and where he wants to be. This is a technique from MI. Additional information on MI can be found in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT, 1999b).

JUAN: Make a plan for how somebody wouldn't take it away from me.

COUNSELOR: How you'd be able to hang onto it, yeah. So that would mean income. Let me ask you this: When you got your last place, how did you do that?

JUAN: Uh, I got on assistance and they just took the rent out of that, so I never saw the rent check. But I got kicked out 'cause I had friends over, and we were partying. It got loud and somebody got into a fight, and then somebody else called the police. The next week I was out. I still get my disability assistance from the government.

COUNSELOR: So, a couple of things happened there. You got on assistance that paid the rent, you got your place, and then your friends came over and had a party. Things got loud and people started fighting, and that caused a problem.

Master Clinician Note: The counselor gathers housing history information and summarizes what Juan says to reinforce her understanding of how he lost his housing. Reflecting Juan's response empathically helps him feel heard and accepted and builds a mutual understanding of the issues they will need to address to make his plan for housing work. The counselor carefully avoids blaming Juan for losing his housing.

JUAN: Yeah. It's not like other people weren't having parties. They were having them every weekend, so I had a party, and the next week, I'm out of there.

COUNSELOR: It didn't make any sense to you that you were bounced out and other people got to stay, even though they were having the same kind of parties.

JUAN: Yeah. I don't want rules for when I can come and go or who I can have visit and stay over.

COUNSELOR: You want to be able to come and go as you please.

JUAN: Yeah. Just like anybody else paying rent for an apartment.

COUNSELOR: What other sorts of things do you think would be reasonable for a landlord to ask from you? Paying rent, that's one.

Master Clinician Note: Given Juan's history of homelessness and tendency to be irritable, the issue of reasonable expectations of a landlord is a touchy one. To avoid provoking Juan, the counselor is eliciting and reinforcing his understanding of reasonable expectations from a landlord.

JUAN: Pay for your rent. Take care of the place. Don't smash in the walls. Stuff like that.

COUNSELOR: Okay. So you wouldn't tear the place up and you'd pay the rent. The only other thing from the last story is that it sounds like maybe your guests might get a little loud.

JUAN: Yeah. I mean, what can you do in that situation? You ask the guys to keep quiet. If you try to throw them out, you may get hurt yourself.

COUNSELOR: You're not real sure what to do if they start being that way.

JUAN: Right.

COUNSELOR: So if we're going to make a plan, we might need to include some ideas about that for you.

JUAN: Like, no parties?

COUNSELOR: Well, how to deal with that kind of situation. We could look at your options and see what you'd like to do. How does that sound to you?

JUAN: You mean you're offering me a place now?

COUNSELOR: I'm offering to work with you to help you see if it's something you want.

Master Clinician Note: If the counselor agrees with Juan's understanding of her offer, then she's agreeing to help him find a home before they have agreed on how they'll work together to help him keep it. She's balancing good judgment with moving at his pace. From his history, she knows that if he's housed without being confident that he can adhere to the terms of a standard lease, he'll be at high risk for a return to homelessness.

JUAN: Yeah, I mean, I'd like that.

COUNSELOR: Well, there are a couple of things that you and I need to do. The first step is to begin to fill out an application where I'm going to ask you for—

JUAN: [*interrupts*] Filling out lots of papers?

[As they move toward beginning the process, Juan experiences more intense ambivalence. The counselor expected this and responds to it with acceptance.]

COUNSELOR: It's not pleasant, is it. How do you feel about that?

JUAN: [*irritably*] Eh, I don't need to get into that stuff. If that is where this is going, I don't want to go there. I don't need that stuff.

COUNSELOR: Okay. I can appreciate that.

[Juan's ambivalence intensifies. He backs his chair away and leaves, ignoring the counselor's request for him to wait. The next time she sees Juan, she tries to approach him, but he walks away.]

Visit 2 (shelter)

A few days after the first visit, the counselor finds out that Juan is at the shelter and stops by in hopes of bumping into him. Her goals for this meeting are:

- To reengage him.
- To offer him the opportunity to look at an apartment that has become available.
- If he wants the apartment, to see whether he can create a plan that will help him keep it.

Juan is cranky but agrees to talk to the counselor. He says he's been in the shelter for 4 days, that a staff member is badgering him into substance abuse treatment, and that he's getting ready to leave. Noting the opportunity, she reflects his wish for new accommodations and offers to take him to see an apartment.

COUNSELOR: So, you could use some options like maybe having a place to stay. We have an apartment that's become available, and the last time we talked, you sounded like you might be interested in something like that if it could be worked out to your satisfaction. I wonder if you'd be interested in taking a look.

JUAN: [*suspiciously*] Now?

COUNSELOR: Yes, I have a van here and a coworker from my outreach team. We can take you.

JUAN: All right, where is it? Not around here?

COUNSELOR: Well, it's not immediately around here. It's a few miles away.

JUAN: Well, I kinda like *this* part of town.

COUNSELOR: So that would be a big change for you, being way over there. Tough decision whether to go see a place that far out of your usual space. But, it's near a bus stop.

JUAN: Sure. Well, I'll go take a look at it.

[The counselor and her colleague drive Juan to the apartment. As she shows him the building, he mentions a landscaping job he had. He's proud of his landscaping abilities and describes being fired.]

JUAN: Yeah, I changed the garden around to make it better, and they told me I was doing stuff I wasn't supposed to do. They just didn't know what they were doing. I said, "I'm outta here."

COUNSELOR: I see. So as far as you're concerned, they didn't appreciate that you were taking initiative to try to make things better.

JUAN: Oh, yeah! Right on.

[They look around, and the counselor tells Juan he can move in when the paperwork is approved and they are able to reach an agreement to help him keep this apartment.]

COUNSELOR: We have to do the paperwork and work out a plan that makes you and everyone else feel confident that you would be able to keep this place.

JUAN: Like whether you're bringing in bags with bottles in them, or… ?

COUNSELOR: No, they don't complain about people bringing in bags with bottles in them. Remember that party you were talking about where things got heavy and the cops came? That's the sort of thing that would cause concern. You and I are going to have to figure out what the program guidelines are and what that means for you.

> **Master Clinician Note:** Juan is in the precontemplation stage of change for substance abuse and the contemplation stage of change for housing (see Part 1, Chapter 1, of this TIP). The counselor is seeking to enhance the relationship with him to support his engagement—first to obtain housing and then to help him move toward acting on other issues in his life, particularly his substance abuse.

[Juan agrees to go back to the shelter to start the paperwork despite his ambivalence. At the shelter, the counselor begins to collect information about Juan's housing history for the application. She mentions the party that led to his most recent eviction.]

COUNSELOR: We started talking about the parties and how those can disturb other people.

JUAN: Well, it's not like other people didn't have parties. I didn't complain about that.

COUNSELOR: So this is one of those areas where it may feel like you're being treated unfairly.

> **Master Clinician Note:** Again, the counselor is careful to reframe this issue to be about Juan's experience of what happened and avoid making him feel blamed, judged, or disrespected by the counselor. This is especially important given his sensitivity to feeling criticized.

JUAN: [*irritably*] I can tell you, I'm not gonna stop having my friends over.

COUNSELOR: Okay.

JUAN: [*still irritably*] What's the point of having your own place if you can't do what you want? I'm not saying they're gonna come over and bust the place up. I don't want that, either. But…

COUNSELOR: Well, you don't want people to come over and bust the place up and neither would any landlord. That makes sense to you. That seems reasonable.

JUAN: Yeah, sure, yeah. But these guys weren't fighting, nothing got broken, and they weren't any louder than the couple next door hollering at each other all the time.

COUNSELOR: Right. So, you feel like the thing that happened last time, the thing that caused the problem, you didn't feel it was as big a deal as they made it out to be.

JUAN: No. No way!

COUNSELOR: There really wasn't anything there for them to be concerned about at all.

Master Clinician Note: The counselor is using a technique known as "over-reflecting." This deliberate emphasis on Juan's initial opinion concerning the episode invites him to think more deeply about the episode and his feelings, evoking self-reflection, especially because he is a person who may not spontaneously self-reflect. There are risks with this approach—such as provoking defensive anger—but if presented with a nonconfrontational and supportive tone, even the most sensitive people will not respond negatively.

JUAN: No. They just didn't treat me right—with respect.

COUNSELOR: That was the problem; it felt like they were kind of singling you out.

JUAN: Yeah. And then that guy upstairs was always playing that #*%! speaker—I could feel the #*%!ing thing in my ceiling. Nobody else complained about that! They didn't kick him out.

COUNSELOR: Uh-huh. So part of what made you so angry the last time was that it seemed like everybody else was doing this stuff and not getting into trouble for it. You were the only one.

JUAN: Right!

COUNSELOR: It's hard for you to see what was different about your situation that got you kicked out.

JUAN: There wasn't anything different about this! They just need the excuse of their #*%!ing rules! I think it's better sometimes just to camp out. Nobody tells you what to do.

COUNSELOR: One of the things that's easier about camping out is that you don't have to deal with other people's ideas about the things you're doing.

JUAN: Right. If things get bad there, you just move off to another place, and that's cool.

COUNSELOR: That's right. You just keep moving around when it starts to get bad. So that's some of the good stuff about camping out; you don't have to put up with other people's complaints. If we're going to make this apartment work for you, we need to figure out how to help you manage those situations. I can't guarantee that the housing manager won't have some opinions about any parties you might throw.

Master Clinician Note: The counselor identifies a potential challenge for Juan in maintaining stable housing. The counselor avoids an adversarial stance by also commenting on the client's coping mechanisms in an accepting manner. Thus, the counselor attempts to begin to frame the issue of housing stability as an objective "problem" that would need to be "solved" by Juan with the counselor's support.

JUAN: Those guys, they weren't fighting, they were arguing with me. Maybe they got a little bit loud, but they didn't bust up the place.

COUNSELOR: That's another thing that might happen, right? You might have some friends over and they might just be hanging out, and somebody else might complain. That'd be tough for you to deal with.

JUAN: Yeah. What's the use of moving into a place and you have some friends over and somebody complains and they kick you out in a week? [*angry, dejected, and disgusted*] Hell, let's just give it up. I don't want to mess with this anymore.

COUNSELOR: Okay, I appreciate that.

[Juan abruptly leaves.]

> **Master Clinician Note:** The counselor knows that a lot is at stake for Juan; if he tries and fails, he might feel humiliated, so he's avoiding the risk of failure. This is a common response for people experiencing homelessness who are considering making a change. Some clients may experience ambivalence about change more intensely because failure causes them intense humiliation. Understanding this makes it easier for the counselor to accept Juan's ambivalence.

Visit 3 (soup kitchen)

Juan disappears for a few days. When he shows up at the soup kitchen, he looks like he hasn't slept for several days, seems to have been using, appears especially unkempt, and has a black eye and other bruises. The counselor asks if she can sit down. He shrugs with a disgusted look but says okay. She takes a seat.

The counselor says that Juan doesn't really look like himself today. Juan explains that he was attacked by someone outside the shelter. She asks whether he's had any medical attention. Juan says no and that he's not interested in getting any. He's not seriously injured, though his bruise looks ugly; the counselor's anxiety increases on seeing Juan's condition. She notices her anxiety and consciously relaxes so she can honor his freedom of choice instead of trying to push him to accept health care. She also notes that Juan gets into pretty serious fights despite portraying himself as someone who stays out of them. Juan agrees to have the counselor check in with him later.

The counselor discusses Juan's condition with her supervisor, and they decide that she should continue to check on him over the next couple of days and watch for any changes in his functioning. If she notices a decrease in his ability to function, she will address this again with him and with her supervisor.

Visit 4 (soup kitchen)

When the counselor finds Juan in the soup kitchen several days later, he looks better. His eye is healing, he's sleeping and eating better, and he has a decent spot on the street where he can get out of the weather. Her goal is to engage him into housing and other services.

COUNSELOR: So you're feeling like staying at this construction site is working for you?

JUAN: Just a little while. I mean, when they start opening up the fence and bringing in the big equipment and stuff, I won't be able to stay there. Are you still putting people in those apartments?

COUNSELOR: I certainly am. You think you might be interested in that?

JUAN: I don't know. There's all that rules stuff, people telling you what to do.

COUNSELOR: Well, it's a tough decision.

JUAN: On the other hand, I might only be able to stay at this construction site for another week.

COUNSELOR: You're getting to the point where you need a more permanent plan for where you stay.

JUAN: Yeah, it would be nice.

COUNSELOR: Yeah. You want to talk about it some more?

JUAN: Yeah.

COUNSELOR: One thing we ask is that you stay in the shelter a few nights before going into an apartment so we can get to know you a bit. We want to ensure that the housing fits your style and priorities.

> **Master Clinician Note:** The counselor avoids confrontation and allows Juan to save face while also emphasizing his need for success. *Note:* Housing First models generally don't require potential clients to spend any amount of time in a shelter prior to entering housing. Getting to know or assessing the client can occur on the street, in the Housing First program offices, or at sites in the community.

[Juan is concerned about returning to the shelter where he had the fight, because they made him leave. The counselor says some of the shelter staff members are familiar with Juan and his situation, and she'll talk to them about helping him possibly get his shelter housing back. Several days later, when they discuss Juan's situation with the shelter staff, Juan agrees to the shelter's rules and says he'd like to stay there until the apartment paperwork is complete and approved.]

Visit 5 (shelter)

Megan talks with shelter staff the next day and checks in with Juan. Her goals for the visit are to:

- Collect information for the housing application.
- Create a plan to address the issues that have caused Juan to lose housing in the past.

The counselor tells Juan that he has impressed the staff by staying out of arguments and not causing problems. She emphasizes this as Juan's accomplishment to reinforce his sense of pride in adaptive behavior. As we pick up the session, the counselor is collecting information about Juan's housing history.

COUNSELOR: So far, there are a couple of things I know. I know you've had an apartment before. And we've talked about what happened with that apartment. I'm wondering about other places you've lived.

JUAN: Actually, a couple different places. I had a friend, Tom. We shared a place for a while.

COUNSELOR: And how did you get that place?

JUAN: He got it. I don't know. He just asked me if I wanted to move in and split the rent.

COUNSELOR: Okay. And how were you affording your rent at that time?

JUAN: I was hustling, moving product—drugs and stuff. I didn't have a regular type job.

COUNSELOR: That's how you were getting the money to pay the rent and to use?

JUAN: Right.

COUNSELOR: So, that was one apartment you had with Tom. How long did that last?

JUAN: I guess about 2 months.

COUNSELOR: What other places?

JUAN: Well, when I was working for that landscaper, I had my own place for more than a year.

COUNSELOR: Oh, so that worked out well. That's a long time to hold on to a place.

JUAN: Yeah.

COUNSELOR: So you had the job first, and then got the apartment on your own.

JUAN: Yeah, those were some good times!

COUNSELOR: You liked that work, and you were good at it.

JUAN: Yeah. I liked being outside, working with the plants, seeing stuff grow and look nice.

[The counselor gathers the rest of Juan's housing, substance abuse, family, financial, and health history. The longest he's been housed is a year. He loses housing because of drug use and fighting. It's important to him to spend time with friends. The counselor notes that he will need positive social supports to maintain his housing. He reveals that he's on parole but hasn't seen his parole officer (PO) in 10 months. He's worried about an outstanding warrant. They discuss the need to address his legal issues, and the counselor offers her support through the process. Juan expresses some discomfort talking about his parole issues. Agreeing to set this aside for now, the counselor shifts the focus to Juan's relationship with his family.

Juan's brother lives upstate, and his parents live in town; he hasn't had contact with them for 3 years. He doesn't make contact with them because he believes that they're going to worry about him. The counselor believes his family could help support Juan's recovery. Once he's settled, he may be interested in inviting his family to his apartment, which could open a discussion about how his having an apartment is great but may also prompt conversation about his drug use. When the time comes to create a plan with Juan for substance abuse treatment, the counselor will ask about his interest in including his family in that plan.

The counselor assesses Juan's substance use and other likely problems based on what she already knows. They will use the information to create a plan to support housing stability and recovery. The counselor continues to gather information on Juan's substance abuse.]

COUNSELOR: We talked already about your use of crack. I wonder what other drugs you might use.

JUAN: I smoke a little grass every once in a while. Not on a regular basis.

COUNSELOR: So every so often, some pot. What else?

JUAN: I drink to come down. Wine helps me get to sleep.

COUNSELOR: Wine. What else?

JUAN: That's pretty much it, and all that other stuff I mentioned.

COUNSELOR: So you use some grass and some wine to come down. But the one you use most is crack.

JUAN: Yes.

> **Master Clinician Note:** Asking "what else?" and reflecting the client's response invites the client to elaborate. This lets the counselor explore client motivation for substance use without evoking resistance. Similarly, in the next exchange, she uses "tell me more" to gather details about psychiatric symptoms.

COUNSELOR: Okay. I'd like to ask you a couple of questions about just how you have been feeling. Have you been feeling depressed, sad, like you are not enjoying things that you might usually enjoy?

JUAN: I haven't been too good up here [*points to his head*] the past few weeks, so—

COUNSELOR: Well, tell me more about the past couple of weeks.

JUAN: I always wake up in the middle of the night and can't get back to sleep with guys playing music at the shelter and stuff, and that pisses me off.

> **Master Clinician Note:** The counselor is attempting to maintain and build the relationship with Juan through reflection, restating, and paraphrasing his comments. This is an effective technique from MI, although the counselor needs to be aware that the technique can be overused. If overused, rapport with the client will suffer.

COUNSELOR: So you are having some trouble sleeping. What else is going on?

JUAN: That's pretty much it.

COUNSELOR: That's pretty much it. What about feeling anxious or irritable and angry?

JUAN: Well, yeah. All those things.

COUNSELOR: All those things from time to time. Is there ever a point where they are really causing big problems for you or getting in the way of other things you want to do?

JUAN: Yeah. I walked off that job. That was a dumb thing to do.

COUNSELOR: So that's one case of feeling angry and making a choice you didn't really want to make.

JUAN: Yeah, that wasn't a good thing to do. It happens.

COUNSELOR: I hope that when you get settled in your apartment and when things are going better, we can talk about what happens when you get angry and get yourself in trouble.

JUAN: Yeah.

COUNSELOR: Juan, tell me some more about your sleep problem.

JUAN: Well, the wine just levels me off, helps me get to sleep. But then, when I drink a lot of wine, I wake up in the middle of the night and I can't go back to sleep.

COUNSELOR: Yeah, so that's sort of interfering with your sleep, too, you've noticed.

JUAN: I can't get to sleep without it, but then I wake up in the middle of the night.

[The counselor is supporting the client's growing awareness of the relationship between sleeping problems and substance use patterns.]

COUNSELOR: You drink wine to come down and fall asleep, but you've noticed that when you drink, you wake up in the middle of the night.

JUAN: Yeah, but it's better than going for a couple more days without getting any sleep.

COUNSELOR: How much sleep do you usually get?

JUAN: Don't know… 4 or 5 hours, maybe.

COUNSELOR: How much do you think you need?

JUAN: Maybe 6 or 7, 6 and a half hours.

How To Summarize for Your Client

Be concise. This makes for clarity and easier processing for the client. When summarizing:

- If possible, use the words and phrases the client has used.
- Be as accurate as possible in restating what the client seems to be trying to say. Try to not exaggerate or minimize what the client has said.
- Use phrases such as "What I am understanding is…" or "It seems that you're saying…" and check with the client to see if your understanding is correct.
- If the client says you are not understanding, ask him or her to tell you again and use the client's words in your feedback.
- Sometimes, it may be important to let the client know that understanding what he or she is saying does not imply approval of potential actions. For instance, if a client says they want to hurt someone else, be sure your feedback does not imply that you agree with their intent.

COUNSELOR: How often do you usually get that?

JUAN: Huh! Almost never.

COUNSELOR: Not very often. So you walk around sleep deprived most of the time.

JUAN: Well, I never really thought about it that way. I'd like to sleep longer.

COUNSELOR: Yeah. You and I could work on ways to get a good night's sleep, and you've already connected wine with trouble staying asleep, and you have trouble falling asleep.

JUAN: Yeah. Without the wine, I lie in bed a long time before I drop off.

COUNSELOR: We could see what we can do to help you, if you would like us to do that.

JUAN: I don't know what, but yeah, if something can be done, I'm all for it. Maybe later.

Master Clinician Note: The counselor suspects, from the symptoms Juan has described, such as depression, anger, and anxiety reactions, that he might have a trauma disorder, but she avoids probing his trauma experience, which might, given his situation now, destabilize him and/or disrupt their developing rapport. Instead, she focuses on Juan's main related concern: sleep. She helps him see how these symptoms may be related to substance use. Once Juan has stabilized in housing and is possibly more receptive to engaging in counseling, she will help him access care for both his substance use disorder and, if necessary, his trauma disorder. For more information on working with clients who have trauma symptoms, see the planned TIP, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, planned h).

COUNSELOR: Okay. Do you ever have any beliefs that other people don't have, or do you see things other people don't see or hear things other people don't hear?

JUAN: No. I'm not crazy, man.

COUNSELOR: That's not you. Are there other problems you want me to be aware of at this point? Anything else that you would like us to work on?

JUAN: Just the apartment.

COUNSELOR: The apartment. So at this point, we've completed this paperwork. The housing program will discuss this application, and we will get an arrangement that we can all agree to.

JUAN: Okay.

COUNSELOR: So, some of the things we've talked about working on are sleep, legal issues, anger, and how to manage things when situations aren't fair. Is that about right?

JUAN: So when can I move in?

Master Clinician Note: Juan doesn't respond with "yes," which shows that he's not yet committed to working on these issues. The counselor must reexplore the issues with Juan to identify which ones he's ambivalent about.

How To Prepare a Client for a Conversation With a Parole Officer

When your client agrees to contact his or her PO to explore options, help prepare as follows:

- If your client isn't ready for treatment yet, it's reasonable to expect him or her to leave if the PO says going back either to jail or to treatment is necessary. Discuss the consequences of leaving (e.g., the possibility of being remanded to jail) and tell your client that, no matter the outcome, he or she is welcome to come back for help in the future.
- If your client is ready for substance abuse treatment, you can indicate that sometimes, when people agree to accept treatment and stay in it for a while, POs agree to remove the warrant.
- If parole concerns are a significant burden to your client, help him or her envision what it will be like to be rid of them. The PO might require substance abuse treatment or enforce jail time, but after, it will no longer be a concern. If needed, the two of you can work together on a plan for making it through treatment or jail time.

COUNSELOR: Well, we went over a lot just now. We want to make the housing plan really work for you. Next, we'll review your application and get our agreement in place. You can have a little more time to think about what I just summarized as part of your plan. Tomorrow, let's review the whole thing and make a housing plan we feel really good about—one that will give you the best shot at making it stick with the landlord. Now, let's talk about contacting your parole officer and get that sorted out.

JUAN: Yeah, well, I'm outta here if the PO's got a warrant on me.

[The counselor and Juan proceed to discuss what is going on between Juan and the PO. Juan and the counselor briefly role-play Juan talking to the PO.]

COUNSELOR: Do you want to call him now, while I'm here?

JUAN: That sounds okay. If he doesn't go along with this, then everything else is out.

COUNSELOR: Right. We should talk with the PO first. We can use the speaker phone to hear both sides of the conversation. We'll see how that goes, then decide about talking to the team about your plan.

JUAN: Yeah, let's do that.

COUNSELOR: Juan, I'll need you to sign this "release of information" form that authorizes me to talk with your PO and provide him with information about our work so far. Is that okay?

JUAN: Okay, where do I sign?

[The counselor helped Juan prepare for his meeting with the PO by using some of the guidelines noted in the how-to box above. Juan's PO determined that he could avoid incarceration if he stayed in the shelter for homeless services. Juan did move into the Housing First program, and he and the counselor continue to work on his multiple problems. Likewise, the counselor continues to work on engagement, helping Juan move from precontemplation to the contemplation stage with his substance abuse. The counselor, using MI methods, has helped Juan examine how his ambivalence and sensitivity often prevent him from initiating actions that could be helpful to him.]

Summary

Juan's story took place in the O&E phase. The work focused on:

- Establishing a trusting relationship through nonintrusive persistence.
- Identifying acceptable goals to work on.
- Maintaining teamwork among the counselor, Juan, and the interagency O&E team.

Teamwork was central to Juan's willingness to talk to the counselor, see the apartment, regain access to the shelter (and thereby move toward housing), begin the application process, and explore his legal status.

The counselor helped Juan move through the stages of change by prioritizing Juan's most important goals. Juan began in precontemplation for substance use and mental disorders and the contemplation stage for housing. Housing became the highest priority goal; this let the counselor and Juan identify barriers to maintaining stable housing and reasons to engage in other services. Juan is now in the action stage for obtaining housing and the contemplation stage for substance abuse, mental illness, and legal issues.

Juan's personality problems, such as his hypersensitivity to criticism, his feelings that people are against him, and his sudden anger, may be his most challenging issues. They will be identified as concerns in his treatment after he becomes abstinent, manages trauma disorder symptoms, and develops a resilient, trusting relationship with his treatment team. At this phase of homelessness rehabilitation, the clinician can address behavioral issues by:

- Demonstrating respect for and acceptance of his feelings (e.g., anger, sense of unfairness).
- Helping him see how his behavior (e.g., hosting loud parties, leaving his job) contributes to his homelessness.
- Setting a goal of working on alternative responses to problem situations.

Longer-term goals for this client will include:

- Creating a plan that Juan is confident he can accept and comply with for housing.
- Reconnecting him with family and other natural recovery supports.
- Working with treatment providers to engage him in substance abuse treatment.
- Reconnecting him with employment and other meaningful roles in the community.
- Addressing his parole obligations.
- Evaluating him for mental disorders.

Vignette 2—Francis

Overview

Francis is in the outreach and engagement phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for responding to his health and safety concerns.

Francis is a 54-year-old man who is chronically homeless and has limited interpersonal and intellectual resources. He is now a loner and has had difficulty in the past maintaining a place to live. He currently lives in a subway tunnel, is suspicious of anyone who approaches him, and worries that the transit authority will put him out. He can be personable, and he often spends his day at the entrance to the subway. The outreach team has learned that Francis has occasionally gone to

the local community health center, which is a Federally Qualified Health Center (FQHC; see the text box on p. 81), during the past 4 years. According to his clinic records, he has mild intellectual disabilities (intelligence quotient [IQ] near 70) and may have cognitive impairments as a result of a head injury incurred many years ago. He receives a small disability check monthly. The money is managed by a designated payee, a person who is authorized to help Francis manage his money. He also receives Medicaid as a result of his disability.

The program has been in contact with Francis for some time. He has always walked away after insisting that he is fine and doesn't need anything. The O&E team has new information from area shelters that he's building cooking fires in inappropriate places. In addition to his cognitive impairment, he has significant health problems, including diabetes and nutritional deficiencies. This information, along with an impending severe cold spell, mobilizes the O&E team to persist in trying to engage Francis in services.

A team of two counselors plans to meet him, briefly assess his situation, offer material goods, and establish a relationship. Getting him to accept shelter, health care, and ongoing support are long-term goals. The present goals are to engage him in any possible way to improve his safety and to find opportunities to offer other services.

Maintaining the safety of O&E team members is a critical element of this type of work. Francis's location has been reviewed and approved as safe by the team. (Sample safety policies and procedures are located in Part 2, Chapter 2.)

Setting

The counselor team is part of a multiservice organization serving homeless populations; its street outreach component is staffed by peer counselors, substance abuse specialists, psychiatric social workers, and consultant psychiatrists. It has a drop-in center, housing resources, a working agreement with a local FQHC, and ties to community homelessness programs.

(Note: The designation of FQHC is based on specific funding and reimbursement criteria. There are a number of community health centers that may have an FQHC designation; however, there are other community health clinics and health centers that may not.)

Learning Objectives

- Build rapport (offer material goods; engage in casual conversation; work at the client's pace; show empathy, respect, and genuineness).
- Assess the severity of the client's problems (e.g., safety, health) and develop responses.
- Work with others as part of a team.

Strategies and Techniques

- Outreach
- Match client and counselor
- Service coordination with a local health clinic, a Federally Qualified Health Center

Counselor Skills and Attitudes

- Build rapport.

- Work collaboratively with the client and others.
- Recognize and accept the client as an active participant in prioritizing needs.

Vignette

Visit 1 (Francis's camp)

During this visit, the team will:

- Initiate a relationship, begin to build trust, and establish rapport.
- Offer Francis food and a blanket.
- Tell Francis the weather is turning cold and offer to take him to a shelter.
- Assess Francis's condition.

The two counselors slowly but casually approach Francis, who is seen lying down and snoozing among some of his belongings. He's bearded, disheveled, dressed in dirty clothing, mildly malodorous, and grimy. He is a large man, but he seems physically weak and malnourished. He awakens spontaneously as they approach but is unfocused and seems confused. Team members introduce themselves and shake Francis's hand. He doesn't know who they are and, fearing police or transit officials, he gets up, covers some items, picks up others, and begins moving away.

COUNSELOR 1: Hey.

FRANCIS: Hi.

COUNSELOR 1: How are you doing?

FRANCIS: I'm good.

COUNSELOR 1: Good. My name is Alex, by the way. [*gestures to colleague*] This is Tommy. [*Francis acknowledges them minimally.*] We were just coming by here and noticed that you looked kind of down in the dumps a little bit. How are you doing?

FRANCIS: I'm fine.

COUNSELOR 1: Good. Did we startle you?

FRANCIS: Are you the police?

COUNSELOR 1: Oh no. We work down here in the tunnels and meet people who may be living down here or staying down here. Have you been down here for a while?

How To Engage People Who Are Living on the Street

Several tools can help outreach workers engage a person who is living on the street:

- Observe from a distance to get a sense of what the person may need and how he or she is doing.
- Approach respectfully. Ask to join the person at his/her bench, campsite, or other personal area.
- Offer safety-related items that he or she appears to need (e.g., food, shelter, blankets, water).
- Resist the temptation to offer items solely for comfort rather than safety, as this may support the client in refusing services. The goal is to develop an empathic relationship that respects the client's wishes and creates opportunities to help the person become housed and enter treatment.
- Unless the individual indicates a willingness to have a longer conversation, keep your interactions brief (about 2 minutes) to avoid wearing out your welcome.

FRANCIS: Yeah.

COUNSELOR 1: What's your name, sir?

FRANCIS: Francis.

COUNSELOR 1: Hi, Francis.

FRANCIS: Hi.

COUNSELOR 1: It's getting kind of cold. Can I help you somehow?

FRANCIS: No.

COUNSELOR 1: Okay. Can we sit down?

FRANCIS: Yeah.

[After receiving permission to do so (it is Francis's "home"), the outreach workers sit down. This encourages Francis to stay and talk with them. He makes eye contact and starts to pay attention.]

COUNSELOR 1: So how long you been staying down here?

FRANCIS: Not long.

COUNSELOR 1: Um, I was thinking that it's getting kind of cold out. You said that you were okay. I just wanted to check and see if we could offer you a place to stay indoors.

FRANCIS: No, I'm fine. I went to the health clinic.

COUNSELOR 1: You did? Is that the one over on Second Avenue?

FRANCIS: Yeah.

COUNSELOR 1: I notice that your ankles look pretty swollen and red. Does that hurt?

FRANCIS: A little, but not all the time.

COUNSELOR 1: Is that what you went to the health clinic for?

How To Work as a Team Member on an Outreach and Engagement Team

Agencies often have policies supporting teamwork during outreach. Successful O&E teams collaborate on plans for outreach visits and respect each other's opinions. In Francis's case, the team agreed on the following:

1. O&E will proceed at the client's pace unless there is reason to fear that this will endanger the client (see the decision tree on p. 77).
2. Specific problems will be addressed as the client is willing. Team members work together to create opportunities to offer assistance in resolving these problems.
3. Team members should define roles in advance, especially in terms of who will take primary responsibility for the interaction.
4. Team members should observe which worker the client prefers to speak with and respect that choice. Workers not speaking directly with the client will help in other ways by remaining alert to the needs of both the client and their colleagues.

[Counselor 2 suddenly notes that Francis is becoming uncomfortable, looking away and beginning to pick at his clothes. The counselor assumes that his partner is being too directive with questions and, glancing at his partner, decides to take another approach.]

COUNSELOR 2: How are you doing in the food department? Can I offer you a sandwich?

FRANCIS: Yeah.

COUNSELOR 2: [*handing him a sandwich*] Here you go.

FRANCIS: Thanks.

COUNSELOR 2: Sure. One of the reasons we are down here is that we're moving into a real cold spell over the next couple of days and, you know, when it gets cold, how do you usually manage yourself?

FRANCIS: [*making eye contact*] I'm fine. I have a bag.

COUNSELOR 1: A sleeping bag, you mean?

FRANCIS: Yeah.

[Francis shows the counselor a warm sleeping bag in good condition.]

COUNSELOR 2: Do you need anything else from us? Like a blanket, maybe?

FRANCIS: Um… sure.

COUNSELOR 2: [*handing him a blanket*] Here you go.

FRANCIS: I'm through talking with you now.

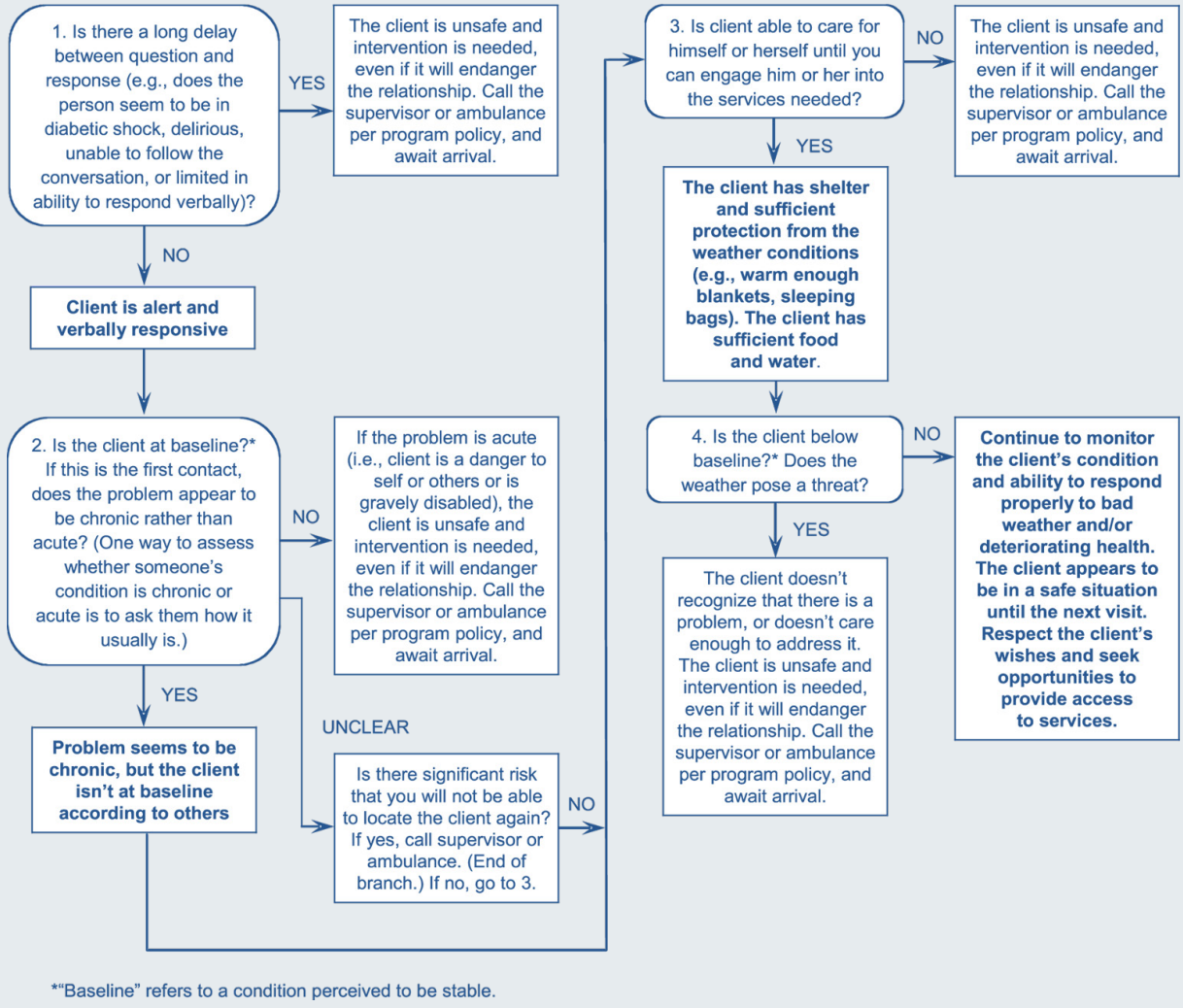
COUNSELOR 1: Okay, I'll tell you what—we'll come back and see you another time. Can we do that?

[Francis agrees, and the outreach team says goodbye and walks away. After the visit, the two counselors report to the rest of the O&E team (consisting of a psychiatrist, a social worker, peer counselors, and a substance abuse treatment provider) and discuss the temperature and whether to do something to ensure Francis's safety. They decide that his situation isn't that bad; he responded appropriately to all questions, is sheltered from the weather, and has a good sleeping bag. They're concerned that he'll move now that he's been approached but decide that his camp looked well set up. That, coupled with his making eye contact and accepting food and a blanket, suggests that Francis will be in his camp the next day. They're concerned about his health and make a plan for the counselors to visit him frequently to monitor his general condition and the condition of his ankles, along with his ability to take care of himself in the cold. If the opportunity arises, they'll try to look at his feet. They plan to engage him in medical and other services at his pace and to take him some socks.

The decision tree on the following page indicates how providers might decide whether and how to intervene when a person who is homeless declines services.]

Decision Tree: Appropriate Follow-Up Care When Concerned About a Person Who Refuses Services

When you detect a client problem in terms of health, cognition, possessions, inclement weather, or change in baseline, you must decide how to respond. In Francis's case, the team decides to monitor him closely and seek opportunities to get him to medical services or bring the services to him. How did they make that decision? This decision tree maps out their process—the team's decisions are in bold.



*"Baseline" refers to a condition perceived to be stable.

Visit 2 (Francis's camp)

The next day, the O&E team members visit Francis again. Their goals are to:

- Offer him their business cards so he has a way to contact them.
- Offer him information about a new, smaller shelter that has opened up nearby.
- Make sure he knows that the weather is going to get even colder tonight.
- Observe his overall condition, the status of his feet, and his ability to take care of himself.
- Give him some socks.

COUNSELOR 1: Francis? It's Alex and Tommy. Remember us from yesterday?

FRANCIS: Yeah.

COUNSELOR 1: Good. Man, it was cold last night! How did you do?

FRANCIS: I did fine.

COUNSELOR 1: I see you're fixing up a little bit more space for yourself here.

FRANCIS: Yeah.

[Francis attempts to stand and stumbles. He appears to be physically uncomfortable.]

COUNSELOR 1: Can we give you a hand?

FRANCIS: No, I'm fine.

COUNSELOR 1: Okay. Hey listen, you know—that shelter up on Avenue A has opened up and there's a spot in case you need it, because it's getting really, really cold. Is that something we can help you with?

FRANCIS: No. I'm fine.

COUNSELOR 1: Okay. Well, we brought some socks for you; would you like some socks?

> **Master Clinician Note:** Giving Francis socks is a nonverbal intervention that shows concern for his health and safety. It shows Francis that the team is connecting with his needs and is interested in building an alliance.

FRANCIS: Yeah. Thanks.

[Tommy hands Francis the socks.]

COUNSELOR 1: We'd also like to give you our cards in case you need to go to the shelter. We'll be around. Is it okay if we come back and see you again?

FRANCIS: Thanks. Yeah, you can come back.

COUNSELOR 1: Okay. Good. Give us a call if you need to. There's an 800 number there. Feel free to just call that number if you need us. We'll come back and see how you're doing in a while, okay?

FRANCIS: Okay.

COUNSELOR 1: There is a telephone right up at the top of the subway entrance, and this is an 800 number, so you don't need to use coins. You just dial this number. Is that okay with you?

FRANCIS: Okay.

Visit 3 (Francis's camp)

On their third visit to Francis's camp several days later, the O&E team has the following goals in mind:

- Continue to develop a relationship with Francis.
- Introduce Francis to the idea of getting follow-up medical care.

- Look for ways to connect him to housing opportunities.

COUNSELOR 1: Hey, Francis.

FRANCIS: Hey, how you doin'?

COUNSELOR 2: Hey, how you doing, Francis?

FRANCIS: Good.

COUNSELOR 1: I heard that you were in the shelter the other day.

FRANCIS: Yeah. I was there for a couple of days.

[Francis struggles to stand up—even though he is obviously in some pain—and he stumbles. The counselor reaches out his hand to help Francis stand and steady himself.]

COUNSELOR 1: Let me give you a hand there.

FRANCIS: Ow! I went to the clinic 'cause my foot was hurting a little bit, and they said I should go to the shelter.

Master Clinician Note: Francis has shown that if he really needs medical care and shelter, he can get them. This indicates that, despite some cognitive impairment, he uses good judgment in at least some situations. Cognitive impairment has a broad range of severity, from mild forgetfulness to full disorientation as to time, place, and person. Cognitive impairment may also be temporary or chronic. Because thinking can become disordered or inefficient, cognitive difficulties can impair judgment by compromising a person's ability to evaluate the risks and benefits of any choice. The causes of cognitive impairment are many, but it may result from a head injury, malnutrition, alcoholism, or acute physical illness. The presence of clear cognitive impairment signals the need for a prompt medical evaluation.

COUNSELOR 1: Yeah, it looks pretty raw right down there. Looks really painful.

FRANCIS: No, it really don't hurt that much.

COUNSELOR 1: Really? I see that your shoes are in kinda bad shape too. So you've been walking around in shoes with holes in them, and it snowed the night before last, too, didn't it?

FRANCIS: Yeah.

COUNSELOR 1: The weather must've been pretty bad on your foot. That's why you went to the clinic?

FRANCIS: Yeah.

COUNSELOR 1: Well, you know, Tommy and I were talking, and we were thinking you could probably use a better place to sleep at a certain point; you know, indoors, in an apartment. Is that something you might be interested in at some point in time?

FRANCIS: Nah. I'm pretty fine out here. I mean, it's not too bad.

COUNSELOR 1: But when it gets cold, it gets a bit rough, and right now it's kinda tough.

FRANCIS: I'm pretty much a tough guy.

COUNSELOR 1: Yeah. I know. How long have you been staying outside? When was the last time you had your own place?

FRANCIS: Oh, about 3 years ago. Yeah, me and my buddy got a place. I moved in. It was pretty nice and everything. He kinda got sick a little bit. My friend passed away.

COUNSELOR 1: Oh, he did? I'm sorry.

FRANCIS: Yeah, it kinda was his place, so I couldn't stay there any longer.

COUNSELOR 1: Got it. You had trouble making ends meet and stuff like that after he passed.

FRANCIS: Well, yeah. It was hard.

COUNSELOR 1: Well, Francis, we'd like to help you find some better housing if you are interested.

FRANCIS: I'm fine.

COUNSELOR 1: Okay. Well, it's something to think about, and we would be glad to talk more about it.

FRANCIS: Okay.

COUNSELOR 1: I'm a little concerned about your foot, though, especially the pain you're going through.

FRANCIS: It's not much pain. I've seen worse. [*rubs his shoulder*] I was shot a long time ago.

COUNSELOR 1: Oh really? Can you use that shoulder pretty good?

FRANCIS: It's fine. Sometimes it hurts a little bit.

COUNSELOR 1: Just so you know, at the clinic there's a nurse in charge of foot problems, and if you'd like, we could take you down there to have her take a look at it if you want.

FRANCIS: You mean Miss Kate. I know her. She's nice. But I don't know. Like I said, it don't hurt that much.

COUNSELOR 1: Okay. It's a little raw. I'm concerned about you with your shoes in bad shape and stuff. You know, at the clinic, they might be able to set you up with a new pair of shoes.

FRANCIS: Can *you* get me some shoes?

Master Clinician Note: This is the first request Francis has made of the O&E team, and they take this window of opportunity to let him know that they want to help him get what he needs. Offering concrete aid like this fosters engagement because it shows Francis that the team will respond to his manifest needs. Counselors will want to be sensitive to clients making a request as a test of whether the counselor and other members of the staff will really respond to the client's expressed needs.

What Is a Federally Qualified Health Center?

A Federally Qualified Health Center is one that is qualified to receive Federal Medicare and Medicaid funds for delivering services to persons enrolled in those programs. In addition, an FQHC program may be eligible for grants to provide services to special target populations, such as individuals and families experiencing homelessness. Typically, FQHCs are found in areas that have large populations of medically underserved individuals and/or in areas with high concentrations of migrant and seasonal agricultural workers, significant numbers of people in public housing, or high rates of homelessness. FQHCs are located in every State.

FQHCs are directed by a community-based board of directors and provide comprehensive primary health care regardless of a person's ability to pay. Fees are based on the individual's ability to pay. Additionally, many preventive services are offered, including screening, brief intervention, and referral to treatment (SBIRT) for individuals at risk of substance abuse and substance use disorders. For more information, see https://www.cms.gov/MLNProducts/downloads/fqhcfactsheet.pdf.

COUNSELOR 1: Yeah, we can bring you some shoes the next time we come. Would it be all right with you if I bring a worker from the clinic? They can help you get medical care for your feet.

FRANCIS: Yeah.

COUNSELOR 1: Okay, great. Take it easy, all right? By the way, what size shoes do you wear?

FRANCIS: I don't know. Size 10, I think. Okay, see you later.

[The team will ask the FQHC clinic's homeless program case manager to join them on their next visit with Francis. They intend for the clinic staff person to become Francis's case manager and help him access medical care, possibly obtain permanent supportive housing, and access other services. During the visit, the clinic case manager will take engagement and intervention cues from the O&E team.

The team feels hopeful that they will get medical attention for Francis's feet on their next visit. Francis has demonstrated that he'll go to the clinic when the pain becomes limiting, but the immediate risk to Francis is that his feet are probably numb as a consequence of his diabetes. This creates a risk of injury and infection, which can lead to serious complications.]

Visit 4 (Francis's camp)

The team approaches this visit with the following goals and strategies in mind:

- The clinic case manager will accompany them and begin to establish a relationship with Francis.
- The team will offer Francis food, shoes, and a ride to the clinic, where he can have his foot examined.
- If Francis fears being coerced into unwanted services, they'll promise to return him to his camp.

Francis is at his camp and is irritable. He didn't go to the shelter and is cold and obviously unhappy. The two counselors introduce the clinic case manager to him.

COUNSELOR 1: Hey, Francis.

FRANCIS: Hey.

COUNSELOR 1: You know, I said we'd be back in a day or two, but we've been thinking about your situation with your foot. We called up the clinic, and they were concerned. Let me introduce Jesse to you.

CLINIC OUTREACH WORKER: Hi, Francis. Yeah, I've seen you come by the clinic a couple of times. I think we spoke once. My office is just as you enter the clinic out of the waiting room, on the right. You know, we can help you with that foot, man.

COUNSELOR 1: Yeah. We can take you to the clinic and then bring you back here if you want.

CLINIC OUTREACH WORKER: Yeah, we can do that. You don't need to stay here.

FRANCIS: I don't need no help.

COUNSELOR 1: A nurse can look at that foot.

FRANCIS: Didn't I just tell you I don't need no help?

> **Master Clinician Note:** The counselor appraises the situation and realizes that the introduction of another person with whom Francis has not had a chance to develop rapport and, possibly, the pressure Francis perceives about getting help are causing Francis to resist. Rather than provoke the resistance, the counselor takes the opportunity to change the topic and talk about the weather for a few minutes. He then returns to the discussion of Francis going to the clinic for health care.

COUNSELOR 1: Well, man, I hope you are going to be willing to let Jesse help you get over to the clinic and get that foot taken care of.

FRANCIS: That's all we're gonna do, right?

CLINIC OUTREACH WORKER: Yeah. It's your call. Can we take your stuff with us?

FRANCIS: Yeah. If you don't take things around here, they…

CLINIC OUTREACH WORKER: Yeah, I know. They get taken by somebody else.

FRANCIS: So are we going to the clinic that I go to?

COUNSELOR 1: Yeah, that's where the nurse is. She'll look at your foot and we'll get some food for you—a sandwich and some hot coffee. How do you like your coffee?

FRANCIS: All black.

[Once the team has promised not to leave him at the clinic, Francis agrees to go with the outreach worker. He's now in the preparation stage for medical care and the precontemplation stage for assistance with housing.]

Summary

This vignette demonstrates counselor skills and attitudes involved in outreach work, including:

- Patience, respect for client autonomy, and trustworthiness.

- Relationship-building skills.
- Ability to respond appropriately to changes in the client's behavior.
- Ability to work as a member of a team and respond appropriately to safety and medical needs.

In the O&E phase, the team's interventions suited Francis's stages of change: contemplation and preparation for medical treatment, and precontemplation for housing. They prioritized the goal most pressing to Francis and his well-being: addressing his medical problems. Interventions to build a relationship and increase readiness for services included:

- Asking for permission and respecting his decisions and personal space.
- Offering incentives (e.g., socks, blanket, shoes, food).
- Increasing access to services (e.g., bringing workers to him, helping with transportation, helping him take his things with him).

Given Francis's willingness to engage *on his terms*, agreement to engage in additional services will also be on his terms. As shown in this vignette, Francis moves forward assisted by the creativity, care, respect, and persistence of the counselors who work with him. The challenge for the counselors is to continuously balance Francis's freedom of choice with the severity of his condition.

Long-term goals for working with Francis include:

- Help him engage in medical treatment at the clinic to stabilize his current medical conditions.
- Evaluate his mental health, particularly in light of his cognitive impairments.
- Make a plan that he's confident he can adhere to for housing.
- Reconnect him with his family and other recovery supports.
- Connect him with other peer-led community recovery supports.

Vignette 3—Roxanne

Overview

Roxanne is in the intensive care phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for preventing homelessness and stabilizing a client who is in the precontemplation stage of substance abuse treatment.

Roxanne is 32 years old, has been diagnosed with antisocial personality disorder, and is possibly dependent on oxycodone and other opioids. She occasionally has sex in exchange for money and sells pain pills for income. Roxanne lives in a supportive housing program, but her behavior has put her housing at risk. Her hostility, impaired ability to regulate her emotions, physical complaints, self-destructive and impulsive behavior, and impaired relationships may be indicative of a trauma-related disorder as well as a personality disorder.

These behaviors may evoke an emotional reaction (countertransference) in the counselor, evidenced in this case by the counselor's anger, frustration, and helplessness. This makes it hard for the counselor to respond effectively to Roxanne's needs. Supervision in such a situation is quite important and can help the counselor clarify boundaries, responsibilities, and strategies for holding Roxanne responsible for her behavior while providing support to facilitate behavior change.

Roxanne's behavioral health counselor has talked to her many times about using drugs, bringing men paying for sex to her single room occupancy (SRO), and "shopping for pills." Even so, Roxanne continues to have her clients "visit" her in her room. She also continues to seek drugs for severe chronic back pain—particularly oxycodone—in local emergency departments (EDs). She has been evaluated on several occasions for pain (including comprehensive studies of her back and spine in the hospital pain clinic), but no evidence of a physical disorder has been found. About 2 years ago, she was referred to the hospital pain management program but did not follow through with their recommendations. She has had two admissions to a local mental health treatment center, both times following arrests for disorderly conduct and resisting arrest.

The clinic suggested that she might have posttraumatic stress disorder (PTSD) and/or a substance use disorder in addition to her personality disorder, but these diagnoses were not confirmed, and Roxanne refused to continue to be seen at the clinic. She did agree to enroll in a hospital case management program for ED users that includes consent to share information with the behavioral health counselor in her SRO. The ED has called the counselor to report that Roxanne is now there and is refusing to leave without medication, even though she has been examined and released with a clean bill of health.

Setting

The behavioral health counselor provides case management services for a community program offering a variety of housing options to clients with a history of substance use disorders or SMI. All of the clients have had mental health and/or substance abuse treatment. The level of recovery varies from very stable to active symptoms that interfere with daily functioning. In most cases, a client's level of recovery determines the housing options available to him or her. In this case, the counselor provides services to clients housed in an SRO supportive housing program funded through the U.S. Department of Housing and Urban Development (HUD). The housing consists of units with a kitchen and bath for occupancy by one person.

Learning Objectives

- Tailor treatment strategies, including the use of incentives, to match the client's motivational level.
- Work with others as part of a team.
- Recognize situations in which supervision is appropriate.
- Work with clients experiencing homelessness who are in the precontemplation stage of change for their substance abuse.

Strategies and Techniques

- Behavioral interventions, including contingency management
- Structuring sessions
- Managing and setting limits on inappropriate behavior

Counselor Skills and Attitudes

- Work collaboratively with the client and others.
- Recognize and accept behavioral change as a multistep process.
- Take responsibility for personal and professional growth (e.g., address countertransference).

- Adjust strategies to suit client characteristics (e.g., using a calm tone to convey safety and control when clients feel out of control, making lists of priorities to structure sessions).

Vignette

Visit 1 (hospital emergency department)

Because Roxanne's behavior is sometimes inappropriate, two counselors go to the ED. Counselor 1 is Roxanne's assigned counselor. The counselors' goals for this meeting are to:

- Help Roxanne leave the ED before she is arrested.
- Set up an appointment for the next day to discuss her concerns.
- Transport her back to her SRO.
- Preserve their organization's relationship with the ED.

They find Roxanne in the waiting area. When she sees the team arrive, she immediately begins insulting the ED staff, loudly complaining that no one is paying attention to her pain.

ROXANNE: That b#*%! is ignoring me! Can't you see I'm in pain? My *God!* No one here cares about anybody but themselves, God #*%! it! Maybe you can help me. Tell them I'm in pain! I'm in pain!!!

COUNSELOR 1: Roxanne…

ROXANNE: Thank *God* you're here! Oh my God, thank you. You gotta tell them I hurt! I'm hurting! My back hurts so much! They don't know what the #*%! they're doing here!

[Roxanne grabs Counselor 1's shirt. Caught off guard by this, the counselor turns his head away.]

ROXANNE: Make them pay attention to me!

> **Master Clinician Note:** Given Roxanne's history and current behavior, it may be that she was not examined carefully. Barring any clear danger to the client, it is important to avoid confronting the ED staff with this possibility at this time. Issues about Roxanne's treatment in the ED can be carefully examined away from the urgency of the moment. Moreover, Roxanne may further escalate her behavior if she senses disunity between the ED staff and her counselor. The team will address Roxanne's own behavior and desire for medication after leaving the ED, minimizing disruption and breach of privacy in the public waiting area.

COUNSELOR 2: Roxanne, listen…

[Counselor 2's calm tone and kind manner catch Roxanne's attention.]

ROXANNE: No, I'm really hurting! You gotta get me some medication, pleeeease! *You* understand. I'm a woman. I have problems. You understand. Can you help me, *please!!* Please! My back really hurts!!

COUNSELOR 2: Roxanne. Can you—

ROXANNE: [*shouting*] Let's go to another hospital! I gotta do something!

COUNSELOR 2: [*calmly but firmly*] Can you go back to the chair, please? Listen, they called us and said they can't give you medication. We'd like to get you in the van and take you home.

> **Master Clinician Note:** Counselor 2's calm, firm tone communicates safety and control, and the simple instructions help Roxanne, who feels out of control, focus and calm down. There are no easy solutions to this situation. If Roxanne had *not* de-escalated, the counselor might next have opted to give her the choice of leaving the ED to discuss further options. She may have said, for example: "You say you want to go to another hospital. Let's go outside, where we can speak more privately and discuss the options." The short walk may have allowed Roxanne to collect her thoughts away from an audience in the ED. The counselor's second option might have been to call security. Although always a potential tool for safety, using this option too hastily may have resulted in a power struggle and led to Roxanne's physical restraint and sedation, the former being highly traumatizing and the latter unintentionally colluding with her demand for medication. This would have reinforced her repeated inappropriate demands. As Roxanne engages in treatment, her providers will assess her trauma symptoms, develop an understanding of how her behavior helps her cope with these symptoms, and integrate this conceptualization into her treatment plan.

[In a quick, nonverbal exchange, the two counselors agree that Counselor 2 will take the lead in interacting with Roxanne. Their training has prepared them for just such situations. They know that if both try to interact with Roxanne, it is likely to create an environment in which Roxanne can play one counselor against the other.]

ROXANNE: What are we gonna do about this God #*%! pain?! That b#*%! isn't helping me.

COUNSELOR 2: We'll set up an appointment. Do you think you'll be ready for one tomorrow?

ROXANNE: I want some meds.

COUNSELOR 2: They aren't going to give you meds here. We already know they've made that decision.

ROXANNE: I hurt. I'm hurting. I'm *really hurting!* Please! Somebody *help* me, please!

COUNSELOR 2: Tomorrow we're going to try and take care of it. Just let me—

ROXANNE: Well, you *better*. I'm gonna sue somebody. I'm gonna sue that b#*%! over there!

COUNSELOR 2: Forget them for now. You know the last couple of times we talked to you about some options, and we can do that again tomorrow.

ROXANNE: I need something for this pain. Can you get me something tonight?

COUNSELOR 2: I can't get you something tonight.

ROXANNE: What am I gonna do, then?

COUNSELOR 2: We're going to get in the van, we'll take you home, and you can get some rest, try to sleep, and get a fresh start in the morning. All right?

ROXANNE: What time?

How To Intervene With a Client Who Is Being Disruptive in a Public Place

1. Compassionate direction can help the client disengage from the situation and calm down. Speak calmly and firmly; give simple instructions (e.g., "look at me," "please sit down").
2. Get the client out of the public place. One way to shift the client's focus is to say, "Your pain is important to us—let's go somewhere where we can talk and make a plan to deal with it the best way we can."
3. You may be tempted to agree to unrealistic requests, like a meeting at 7 a.m. It's okay to set limits by saying, "I'm not able to meet with you at 7, but I can meet with you at 8:30."
4. If you give in, one way to rectify it is to say, "Look, I know we said 7. I was feeling your pain and lost my sense of what I'm really able to do tomorrow. I can't come any earlier than 8:30." Your client may not be pleased with waiting until 8:30, but you're modeling how to handle inappropriate requests, and the client will appreciate that you are being clear about what you're able to do.

COUNSELOR 2: You name it.

ROXANNE: Seven o'clock.

[During the van ride back to her home, Roxanne tests more limits by insisting that she needs pain medication and taking off her seatbelt. The counselors stay composed, calmly telling Roxanne that they'll pull over if she won't put on her seatbelt. They give her the option of getting aspirin at a drug store, which she accepts. As Roxanne begins to calm down, she throws a cup at a counselor. Both counselors stay calm, explaining that her safety is important to them, so they can only transport her if she stops doing things like throwing cups. They say that they want to take her back home as long as she's willing to use her seatbelt and refrain from unsafe behavior. Roxanne agrees to accept the ride on those conditions.]

Master Clinician Note: Reacting with harsh confrontation or a punishing tone to provocative behavior like Roxanne's is tempting. However, the counselors understand that her personality disorder along with possible PTSD make it very difficult for her to regulate her emotions and that it is important to reinforce her sense of safety, control, and empowerment. Additionally, Roxanne has, in the past, often been successful in getting what she wants by escalating her disruptive behavior and becoming provocative. It is important that the counselors recognize the provocation as an attempt to get her needs met and refuse to be manipulated by it. The counselors believe that when Roxanne returns home, she'll buy pills on the street. They could say, "I can see that you're really hurting and I'm worried that you'll do something that may put you at risk between now and tomorrow morning. Let's talk about options." The counselors know that this suggestion is unlikely to influence her immediate choices, but planting the seed helps her develop alternative coping skills to manage her discomfort, and they convey their concern that she might use a maladaptive coping behavior. The counselors also recognize that some of the irritation, agitation, and pain that Roxanne is experiencing may be residual withdrawal symptoms. In subsequent visits, the counselors will focus on helping Roxanne increase her motivation to obtain substance abuse treatment, return to the pain management clinic, and develop coping options when her subjective experience of pain feels like it is becoming unmanageable.

Visit 2 (counselor's office)

Roxanne sleeps past her appointment, although the counselor has telephoned to wake her. When she finally arrives in the afternoon, she doesn't want to discuss her behavior at the ED, preferring instead to make demands on the counselor. The counselor's goals for this meeting are to:

- Reinforce the therapeutic relationship with Roxanne, particularly in light of their encounter in the ED the previous evening.
- Discuss her behavior at the clinic and her other options for pain management.
- Engage Roxanne in a screening process to assess for a possible substance use disorder.
- Help Roxanne understand the requirements of the SRO regarding drug use and visitors.

Roxanne arrives with a list of complaints, including not having water last night and feeling back pain. In response to the counselor's attempt to focus on her behavior at the ED, she becomes even more upset.

> **Master Clinician Note:** The counselor agreed to meet Roxanne at an early hour. When she doesn't appear, he's angry. He also expects Roxanne to be erratic and provocative in today's session, possibly leading to a nonproductive or even contentious session. He needs to prepare for the session, first, by accepting his angry feelings and, second, by carefully preparing constructive responses (e.g., supportive limit setting, keeping goal expectations modest and prioritized) before the meeting.

ROXANNE: I go 'cause I hurt and they ignored me last night! What are we gonna do about this water situation? I had to go out last night to get water, to take some more pills. There was no water. By the way, I got a letter today from public assistance telling me they're cutting off my benefits. Nothing's happening! I don't understand. Somebody here did something. Somebody's got it in for me, I just *know*.

> **Master Clinician Note:** In almost every session, Roxanne has a pattern of raising multiple issues that seem unrelated. If the counselor begins to address one of these issues, Roxanne is likely to change the subject and move to another perceived problem. It is important for the counselor to identify the most pressing issues and help Roxanne stay focused on those issues. Some strategies the counselor could use include:
>
> 1. Assessing and prioritizing problems to address.
> 2. Considering which problems, if effectively addressed, will ease the pressure of or resolve other problems.
> 3. Evaluating which problems Roxanne and the counselor can effectively address and which they cannot.
> 4. Deciding how complex problems can be broken down into several less complicated problems that can be addressed.

COUNSELOR 2: They're concerned about your behavior at your building. The housing manager called and said you're violating the visitor policy and getting into fights with your neighbor. I'm worried about your being able to stay there. If things keep going like this, I'm afraid you're going to lose your apartment.

How To Keep a Client Focused

When treating clients with many demands or problems, the following strategies may help:

- Limit session length at the outset (e.g., "we have only half an hour today").
- Create a list of the client's priorities to help you both maintain focus on treatment goals.
- Stay consistent from session to session. Stick with the treatment plan.
- Be firm but not rigid. Things will occur that dictate a need to change the treatment plan.
- Set goals that are realistic and can be accomplished in a timely manner.
- Identify realistic expectations for client behavior; recognize small successes as progress.

[The counselor decides to focus on the housing issue with Roxanne because if she does lose her housing, it will be very difficult for her to maintain the gains she has made in other areas of functioning.]

ROXANNE: I'm gonna lose my apartment if I don't get my #*%!ing benefits turned back on.

COUNSELOR 2: Well, we don't want you to lose your apartment. So, the next time or maybe the time after when you come in, bring that paperwork for your benefits, and we'll see what you and I can do about you keeping your benefits. But Roxanne, we have to look at what is going on in your apartment. Maybe we can meet—you, me, and the housing manager of your apartment—and see how we can resolve some of these problems. Do you think we could do that?

ROXANNE: That's really not gonna do anything for my pain. My back hurts, and it hurts *all the time*!

COUNSELOR 2: I agree; your pain is difficult. I hope you can get back to the pain clinic at the hospital, but right now, let's see what we can work out about keeping your housing.

ROXANNE: The only thing that helps is oxycodone. It *really* helps.

Master Clinician Note: The counselor realizes that Roxanne is not prepared to focus on any one issue except getting her drugs and that continuing to pursue issues about housing or obtaining substance abuse assessment is going to be futile. He anticipates that continuing to press Roxanne at this time will only increase her alienation and escalate her complaints. He decides to forgo more discussion at this time and wraps up the session with a summary of their visit, reminding Roxanne to bring her benefits papers when she returns for the next visit.

[This was a particularly challenging session for the counselor. Feeling overwhelmed by Roxanne's demands, the counselor knows he should seek supervision. The supervisor affirms the counselor's choice to seek assistance. His supervisor helps him assess Roxanne's problems and then structure sessions, assess Roxanne's readiness for change regarding her possible substance abuse, and identify appropriate interventions while also providing support for the counselor. The supervisor encourages the counselor to continue to address the challenges of working with Roxanne in supervision. Some of the supervisor's suggestions and insights include:

- Support Roxanne's goal to keep her housing; this keeps the door open for her to accept indicated treatment later. Offer options, but don't take responsibility for her choices. She will make her own.
- Help Roxanne increase her motivation to obtain an evaluation for substance abuse treatment.

- Use contingency management (described later in this vignette) to help her engage and stay in treatment if it is indicated. Offer incentives she relates to (e.g., clothing vouchers) for meeting objectively measurable goals that are important to her (e.g., keeping her housing by behaving appropriately in response to complaints, attending pain management for treatment of her back pain). This will help her develop internal motivation.
- Encourage Roxanne to develop coping skills for managing anger. If she becomes hostile, end the session in a compassionate, noncombative way and see her again when she's able to speak calmly.
- Help Roxanne focus during sessions by making a list with her that includes her goals, such as getting help for her pain and addressing concerns about her apartment.
- Spend the last 15 minutes of every session reviewing the items covered during the session, keeping Roxanne focused on her list of goals and ways she can demonstrate that she has reached these goals.
- Reframe her behaviors as strengths. She is skilled at reading people, focused on her own agenda, actively engaged in getting what she wants, and persistent. This will increase her sense of self-efficacy and help her see ways of shifting her behavior toward more adaptive outcomes.
- Continue noting countertransferential feelings in response to Roxanne's behaviors; seek supervision.]

Visit 3 (housing manager's office)

After meeting with his supervisor, the counselor, with the cooperation of the housing manager of Roxanne's apartment building, schedules a meeting with Roxanne, the housing manager, and himself. The manager has been confronted by other tenants who complain that Roxanne is loud and argumentative and may be using her apartment for prostitution. The housing manager notes that if Roxanne cannot be more cooperative, she is going to lose her apartment.

The counselor wants to foster a spirit of teamwork, hear firsthand about the problems Roxanne is creating, and support the housing manager in working with Roxanne to reduce the risk of losing her apartment. The counselor's goals for this meeting are to:

- Assist Roxanne in keeping her apartment; the counselor sees Roxanne's maintaining stable housing as a precondition to addressing other issues, such as pain management, substance use, and management of trauma symptoms.
- Show Roxanne that her concerns are taken seriously.

Trauma-Informed Care

Trauma-informed care is an approach to working with clients who have histories of trauma that recognizes trauma symptoms and integrates this information into treatment planning and delivery. Roxanne's counselors recognize that many of her behavioral symptoms may be a result of significant trauma in her history, and they use that recognition in helping Roxanne develop a treatment and recovery plan that incorporates mental health, substance abuse, and trauma care along with housing. One key strategy of trauma-informed care is empowerment: helping the client take responsibility for his or her own recovery and life. Observe how the clinicians, in cooperation with the housing manager, seek to empower Roxanne. For more information on trauma-informed care, see the SAMHSA-sponsored National Center for Trauma-Informed Care Web site (http://samhsa.gov/nctic/) or consult the planned TIP, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, planned h).

- Create an environment that reinforces adaptive behavior.
- Show that the service team is unified in its approach to her problems.
- Address specific issues raised by a neighbor who has complained about Roxanne's behavior.

The counselor and the housing manager agree that the housing manager will take the lead in the meeting. The counselor will step in to support Roxanne when she identifies positive changes she is willing to make regarding her housing situation.

ROXANNE: Someone stole my public assistance stuff, and I'm sure it was her, because that b#*%! is just out to get me. She has nothing good to say about me. You've gotta take care of that! She slips nasty notes under my door and threatens me for some reason. She's just got it in for me, and I've just *had it* with her!

HOUSING MANAGER: Well, she has some complaints about you too, Roxanne.

ROXANNE: What have *I* done?

HOUSING MANAGER: She says you're always having a lot of men over at your place.

ROXANNE: [*sounding superior*] I'm allowed to entertain anybody I want.

HOUSING MANAGER: Well, I need you to do some things for me; I have a job to do, Roxanne.

ROXANNE: You just do your job.

HOUSING MANAGER: Well, you're going to have to help me do my job.

ROXANNE: How? You're gonna pay me to do your job?

HOUSING MANAGER: No, this is what I want you to do: Cut down on the traffic to your room.

ROXANNE: There's nothing in the rules that says I can't have people there. I've read the rules. I know what they say. They don't say that I can't have people there.

HOUSING MANAGER: I have just told you I've had complaints from your neighbors, so I'd be willing to work with you if you're not going to—

ROXANNE: She's just got it in for me. I'm not going to say one word to that b#!*%! But I tell ya, when I catch her stealing my mail, she's gone!

How To Prepare for Joint Sessions

1. Support a spirit of teamwork among the staff members who are present: Create a tone that emphasizes that everyone is working toward the same goal.
2. Use the first minutes of the session to set boundaries for the focus of the session, being clear about the issues that will be discussed. Everyone comes to the session with a separate agenda, and things can get out of hand without clear agreement on session goals. Be sure all participants have an opportunity to state their goals.
3. Prepare all participants for the client's likely responses (e.g., coping styles): review the client's history, current issues and goals, and past behaviors in similar circumstances.

How To Manage Inappropriate Behavior

When your client becomes inappropriately seductive and oversexualized with the staff:

1. Pause and identify for yourself what he or she is doing.
2. Consider how this behavior fits with your conceptualization of the client. Inappropriate behavior is part of chaotic relationships.
3. By stepping outside the chaos and observing what is going on, you can identify the seductiveness and label it as an issue to work on in treatment.
4. It is also important to kindly and firmly limit the inappropriate behavior.
5. Use structure (e.g., a list of priorities) to help the client focus.

HOUSING MANAGER: Well, if you catch her stealing your mail, you should come tell me and I'll make a police report. What's going on with your apartment?

[Roxanne continues by listing a variety of problems with her apartment: a leaky bathtub, peeling paint, a problem with her refrigerator, a wall switch that isn't working, and a request for a new mailbox lock because she thinks her neighbor is stealing her mail. The housing manager listens carefully and takes notes of the items that need correcting. Although the housing manager does not commit to making all of the repairs immediately, he does seem to be listening carefully and taking her concerns seriously.]

HOUSING MANAGER: Anything else?

ROXANNE: Well, that's it for now. There's always something. But those are the worst now.

HOUSING MANAGER: So you need a mailbox key, a refrigerator, a new paint job, and the tub fixed.

ROXANNE: When are you gonna do it?

HOUSING MANAGER: What are you going to do for *me*?

ROXANNE: What do you mean, what am I gonna do for *you*? I don't *work* for you!

HOUSING MANAGER: What are you going to give me when I fix these things?

ROXANNE: [*a bit sarcastically*] A "Thank you very much."

HOUSING MANAGER: Now, can I tell you what I want from you?

ROXANNE: Something from me? *I've* got something. [*seductively*] You'll really enjoy it.

HOUSING MANAGER: This is exactly what I'm talking about, Roxanne. This is not appropriate. Let's talk about what we can do with the apartment.

ROXANNE: But you said I was going to have to give you something, so you set me up.

Master Clinician Note: The counselor steps in to interrupt the conflict and redirect the conversation and then steps back to let the housing manager take the lead once again.

COUNSELOR 2: Let's listen to what he would like to have you do. [*addressing the housing manager*] What is it that Roxanne can do to help with this?

HOUSING MANAGER: The main thing that will help me speed up making the repairs is if you're willing to consider not having as many people over in one evening.

ROXANNE: What do you mean, not as many people?

COUNSELOR 2: Limit her guests to just one or two in an evening?

HOUSING MANAGER: Yeah.

COUNSELOR 2: Can you do that?

ROXANNE: Yeah, I can do that.

HOUSING MANAGER: Which of your apartment problems would you like me to address first?

ROXANNE: Uh, my refrigerator.

HOUSING MANAGER: Yeah, I'm not saying I'm going to replace it. I'll replace it if it's not repairable.

ROXANNE: Okay.

HOUSING MANAGER: And we'll take care of the tub.

ROXANNE: Okay. What are you going to do about my neighbor, though?

HOUSING MANAGER: I'm going to talk to her, and I'm going to ask her not to bother you.

ROXANNE: You do that. I won't bother her, believe me. She's gotta stay away from my mail!

COUNSELOR 2: If you think that she's in your mail, will you come to me and let me handle it?

ROXANNE: Yes.

COUNSELOR 2: Okay. So, can we go look at her refrigerator now?

HOUSING MANAGER: Yeah, sure.

[The housing manager leaves the meeting to get the repairman to work on Roxanne's refrigerator. After his departure, the counselor spends a few minutes with Roxanne, supporting her for working toward resolving the problems. He also reinforces the need for Roxanne to limit visitors to her apartment and to bring complaints to the manager rather than confronting other residents directly. The counselor notes that during the entire meeting, Roxanne did not complain of pain or the need for pain pills. He does not mention this to Roxanne, but decides to wait for Roxanne to raise the issue again. He schedules the next appointment with Roxanne for later in the week at his office.

After returning to his office, the counselor calls the housing manager to express appreciation for his skillful work in the meeting, thus building teamwork.]

Visit 4 (counselor's office)

After another meeting with his supervisor, the counselor sets these goals for his next visit with Roxanne:

- Use a list to structure and prioritize the conversation.
- Help Roxanne accept medical treatment with Dr. Thomas, the program physician, who is associated with a local community health clinic. The counselor would like to use the visits with Dr. Thomas as an entry point for getting Roxanne to return to the pain clinic at the hospital, hoping that pain management may be a way to engage her into addressing her substance use.
- Identify some strategies to help Roxanne move from the precontemplation stage to the contemplation stage for addressing her substance use.

Roxanne arrives late, looking exasperated and preoccupied. She apologizes for being late and begins a rapid-fire complaint about her neighbor. The counselor helps her focus on making a list of priorities for them to work on.

COUNSELOR 2: What I'd like to do is talk about the most important things for you *right now*. There are so many things going on. What's the most important thing for us to try to help you with right now?

ROXANNE: What do you mean, "help?" I mean, there's all kinds of things going on.

COUNSELOR 2: Yes, there are a lot of things. Let's see if we can decide which are most important to focus on right now.

ROXANNE: So, you want me to choose which is the most important thing?

COUNSELOR 2: Yeah.

ROXANNE: My back.

COUNSELOR 2: Okay, so we want to concentrate on…

ROXANNE: Then my neighbor.

COUNSELOR 2: Your neighbor?

ROXANNE: My public assistance is still cut off. I got this leaky faucet.

How To Use Lists To Keep Clients Focused

1. Ask, "What are the three most important things for you? It helps me to make a list of what's important." Lists create structure and help the counselor and client stay on the same page.
2. Help the client prioritize his or her most important concerns.
3. When the client veers off, the counselor can say, "Well that's not on the list. Let's talk about your list because those are the most important things. If they aren't the most important, we can change the list."
4. Agree on the time needed for each item to increase structure. "How long do you think we need to handle this item? Also, I need to speak with you about a few things, so I'll need 15 minutes at the end to talk about… "

COUNSELOR 2: So, there are four things.

ROXANNE: I've got this guy after me—I'm real worried about that. And my back.

[The counselor and Roxanne settle on three issues to focus on today: her pain, the man who is after her, and relationships with other tenants at the SRO housing facility.]

COUNSELOR 2: All right, so let's talk first about getting you an appointment with Dr. Thomas about your pain.

ROXANNE: I don't like him.

COUNSELOR 2: He's the physician we can use in this program.

ROXANNE: Can't you find me somebody else? Can't you find me a woman doctor?

COUNSELOR 2: Sorry, we don't have a woman doctor. I understand that you would rather see a woman doctor, but Dr. Thomas is the only doctor assigned to this program. If you see Dr. Thomas and then still want to see another doctor who is female, I can see if we can arrange a referral.

Master Clinician Note: The counselor thinks that Roxanne wants another physician because Dr. Thomas has not given her pain pills on past visits, but he is sensitive to the possibility that Roxanne may want to see a female physician because of a history of sexual traumatization. He doesn't explore that issue right now with Roxanne, but he makes a note to explore it in the future with her.

ROXANNE: [*sighing*] Oh, all right. But he doesn't give me pills for my pain.

COUNSELOR 2: Roxanne, I understand that your pain is a real difficulty for you. But the drugs you want are very addictive, and I don't think you are going to find doctors who will consistently give you the drugs you want.

ROXANNE: No, I need it. It takes away the *pain*. I'm not addicted to it.

COUNSELOR 2: I know you don't think you are addicted. But we need to find some other ways to manage your pain and your drug use.

ROXANNE: Yes. I'm not addicted to it, I mean… I just need something for the pain. I mean, look, if I can't get oxies, I'll buy something else off the street.

COUNSELOR 2: They help?

ROXANNE: Yeah, because the pills take away the *pain*.

Master Clinician Note: The counselor is preparing Roxanne to have modest but substantive expectations of the consultation with Dr. Thomas. By acknowledging Roxanne's pain and eliciting the relationship between Roxanne's pain and her drug-seeking behavior, the counselor enhances rapport and identifies one of Roxanne's needs. The counselor also demonstrates acceptance that Roxanne is in the precontemplation stage of change for addressing her drug-seeking behavior and the contemplation stage for exploring alternatives to oxycodone for managing her pain.

COUNSELOR 2: You can talk to Dr. Thomas about what you might do to manage the pain. You and he can make a plan for what you can do about the pain.

[The counselor raises the issues of the man who is "after" Roxanne and her relationship with the other tenants in her housing, but Roxanne shows little interest in addressing either issue now.]

> **Master Clinician Note:** The counselor suspects that Roxanne's complaints have diminished as a result of her feeling understood and having her needs recognized. With another client at a more advanced stage of change, the counselor might ask if the client feels more comfortable or less distressed than when she came in, and then proceed to explore what happened to initiate the change. But with Roxanne, the counselor suspects this intervention might just invite Roxanne to begin focusing on all that is going wrong in her life and lead her to feel more agitated.

[Roxanne lets the counselor schedule the appointment, and the counselor agrees to talk to Dr. Thomas about attending to Roxanne's concerns. He will also ask Dr. Thomas to consider talking with Roxanne about the pain management clinic and encourage her to accept a referral.

Besides the meeting with Dr. Thomas, Roxanne agrees to continue to bring her concerns about the apartment to the housing manager and not the other residents. Roxanne has a letter from public assistance that she doesn't understand, so she will bring it with her when she goes to see Dr. Thomas, and the counselor can help her with it. This contingency makes it more likely that Roxanne will show up for her appointment.]

Visit 5 (counselor's office)

The counselor speaks with his supervisor about his countertransference with Roxanne and his concerns about forming a treatment contract. They agree on specific goals for the counselor's next visit with Roxanne, which include:

- Remaining consistent with the list of priorities.
- Following up on Roxanne's visit to Dr. Thomas.
- Developing a contingency management program for Roxanne that will support her continuing in treatment and reinforcing changes she has made in pain reduction, drug use, interpersonal relationships, and continuing in treatment.
- Expecting Roxanne to present urgent issues and responding by maintaining a firm but flexible focus on treatment goals.
- Helping her form reasonable expectations of what can be accomplished; keeping the list manageable.

Roxanne reports that, as a result of seeing Dr. Thomas, she's scheduled for a magnetic resonance imaging scan (MRI) of her back and asks what an MRI is. The counselor explains, and Roxanne expresses disappointment that the doctor gave her no medication. She also agreed to schedule a visit to the pain clinic to reenter the pain management program, part of which is a comprehensive evaluation for substance abuse, brief intervention, and referral for treatment, if needed.

ROXANNE: I'm really pissed off 'cause I'm still hurting, and he didn't give me anything.

COUNSELOR 2: Well, I'm really impressed by the fact that you're hurting and yet you came to meet with me, and you worked to get some things done in the apartment.

ROXANNE: My bathtub still isn't fixed.

COUNSELOR 2: Some things are taken care of.

ROXANNE: Yeah, he gave me a new key. I got that.

COUNSELOR 2: Good. I think when you focus, you get things done and people respond to you. That is a real strength that you have.

Master Clinician Note: This intervention identifies and positively reinforces Roxanne's adaptive behavior, thus building her self-confidence and esteem.

ROXANNE: I guess… people just keep bothering me.

COUNSELOR 2: Well, look. I read over your letter from public assistance. It's just a confirmation of your status. Your status hasn't changed. I can be a witness to that.

ROXANNE: What happened?

COUNSELOR 2: It's just a routine evaluation to see whether you're eligible to have continued assistance. You have to sign this to confirm it and I can sign off on it.

ROXANNE: [*after reading the document*] Where do I sign?

COUNSELOR 2: Right here. [*Roxanne signs the document.*] Good. I'll sign as a witness.

ROXANNE: Can I get a copy of that?

COUNSELOR 2: Absolutely. So, you've shown up for the appointments with the housing manager and Dr. Thomas, and you brought your letter as I asked, so I think you're really making some progress here.

ROXANNE: My *pain* is still there, though.

Master Clinician Note: The counselor is participating in a pilot program in the agency to use a newly developed cognitive–behavioral strategy, contingency management, with a few selected clients. Contingency management reinforces positive behaviors toward treatment goals by rewarding the client with vouchers for items that most people would like. Rewards might include special recognitions or program benefits, such as additional hours away from the treatment program. The rewards need to be tied to specific, identifiable, clearly measurable goals, such as clean drug screens, attendance at self-help meetings, and consistent treatment program attendance. Contingency management is generally implemented in settings with a number of clients participating. In this vignette, contingency management is used with just one client. Contingency management is often used in concert with cognitive–behavioral therapy. For more information on contingency management, refer to SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP). Contingency management is also a term sometimes used in housing services, where contingencies, such as staying abstinent, are a condition for housing.

[The counselor briefly explains the contingency management program to Roxanne in terms of rewarding positive, objectively measurable steps toward treatment goals. Roxanne seems quite interested in obtaining vouchers or coupons for products that she might not otherwise be able to purchase.]

COUNSELOR 2: I want to give you a coupon because you kept your appointments with the doctor and the housing manager. I've got a voucher that will get you a free hair appointment. How would you like that?

ROXANNE: I'd like that. Thank you.

COUNSELOR 2: Okay. Next week, if you keep doing well and I get no calls from the housing manager or from the ED, you'll get a voucher for Interfaith Clothing Closet to get some outfits. How's that sound?

ROXANNE: *Now* what do I have to do?

COUNSELOR 2: I don't get any calls that you've been into the ED.

ROXANNE: What if I'm *sick*?

COUNSELOR 2: Well, you're working with Dr. Thomas. You're having an MRI next week, so we have a plan that you're working on. If you get sick in the meantime, call Dr. Thomas.

ROXANNE: What if I have a pain in my back again, like a stabbing pain, and I can't stand it anymore and it's, like, in the middle of the night, and Dr. Thomas is not available?

COUNSELOR 2: If something happens and you have an emergency, then you can go to the emergency room. But if you're going to ask for oxycodone, that wouldn't be following our agreement.

ROXANNE: So I can go to the emergency room, but I can't ask for any pills?

COUNSELOR 2: Right.

ROXANNE: Okay.

[The counselor educates Roxanne about how stress and pain are related, and how there may be other ways to address the pain that may be more helpful than pills. Roxanne refuses to consider going to the pain clinic and steers the conversation back to the emergency department.]

ROXANNE: [*dismissive*] Well, I just know what's gonna happen. I'm gonna wake up in the middle of the night, and I'm gonna be in pain, and I'm not gonna be able to go back to sleep, and I'm not gonna be able to get help because you're telling me I can't go to the emergency room and get some oxies.

COUNSELOR 2: I didn't say you couldn't go to the ED. I said it's not consistent with our agreement if you go to the ED and try to get oxycodone.

ROXANNE: I'm gonna go to the emergency room to get some relief or something.

COUNSELOR 2: So that will be our understanding. If the ED tells me you were requesting oxycodone again, I won't give you the voucher for the Clothing Closet. Do we agree about the voucher and the ED?

ROXANNE: [*tolerant*] I suppose.

COUNSELOR 2: Okay. Well, I think we have everything set up. Now, I'd like for us to put our agreement in writing. Would you like to have that? I promised you a voucher for the Clothing Closet. You could go there and pick two outfits, but in return, the understanding is that you won't go to the ED and ask for oxycodone, and you'll follow through with your appointment with Dr. Thomas next week.

ROXANNE: [*a little confrontational*] And if I don't sign?

COUNSELOR 2: We won't have an agreement, and you won't get a chance to get a couple of new outfits. This is how we both understand what we're agreeing to. What have you got to lose?

[Roxanne challenges the counselor; his calm response enables her to go along with the plan.]

ROXANNE: Can I get some shoes with that?

COUNSELOR 2: I don't know whether they have shoes, but the voucher gets you a couple of outfits. If the outfits include shoes, you could look at shoes.

ROXANNE: Okay.

Master Clinician Note: Committing the plan to paper is a good idea for Roxanne; she'll have it to help her remember what she is supposed to do in order to get the clothing voucher. It also assures her that as long as she follows through, the counselor will, too. Some clients may not need written cues, but when structure and/or ability to remember details are issues for clients, it is a good idea to put agreements in writing.

Summary

The counselor now has the tools to respond effectively when Roxanne is demanding and chaotic. He understands that he can't realistically meet all her needs and doesn't have to. Clinical supervision helped him become aware of his countertransference (i.e., feeling angry, weary, manipulated, challenged, and provoked) and develop ways to manage it so he can respond to Roxanne calmly yet firmly. This approach helps her form a plan to keep her housing, address her back pain, and consider alternatives to oxycodone.

When Roxanne was in the ED, she was in the precontemplation stage of change for finding alternative ways to manage pain, substance use, high-risk behavior, provocative behavior, and housing problems. The counselor's respectful and empowering intensive-care approach (goal setting and reinforcement of appropriate behaviors) has moved Roxanne into the preparation stage for alternatives to managing pain and the action stage for keeping her home and changing problem behaviors. As she succeeds in managing pain and maintaining housing, she may be more motivated to engage in substance abuse treatment.

Long-term goals for working with Roxanne include:
- Continuing to support and reinforce behavior that allows her to maintain her housing.
- Continuing to pursue pain management.
- Obtaining treatment for her substance use, if warranted.
- Increasing motivation to engage in services by exploring and resolving ambivalence; creating a plan that she is confident she can make work.
- Connecting her with acceptable recovery supports (e.g., mutual support groups, faith-based supports).

Vignette 4—Troy

Overview

Troy is in the intensive care phase of homelessness rehabilitation. This vignette demonstrates approaches and techniques for preventing homelessness and engaging the client in substance abuse treatment.

Troy is a 32-year-old single father who is dependent on alcohol and marijuana. He had one brief episode of homelessness in his early twenties, was in substance abuse treatment 2 years ago, and attended Alcoholics Anonymous (AA) regularly until about a year ago. He relapsed about 6 months ago and lost his roofing job. Until his relapse, he had been abstinent for 18 months. The relapse seems to have been triggered by his wife leaving the family, financial difficulties, and dropping out of AA. He says he quit attending AA because he could not arrange child care for his sons, ages 6 and 8. He got custody of his children 8 months ago, after his wife left.

He lacks good childcare, parenting, and time management skills and is easily overwhelmed. When he becomes overwhelmed, he tends to "shut down" and withdraw from others, which increases the environmental stressors. He has food stamps and public assistance but can't cover his rent. Troy has a Section 8 voucher and is afraid that he is about to lose his apartment. For more information on Section 8 housing assistance, see the note on page 103.

Some of the stress-related symptoms he currently experiences include:
- Difficulty staying focused on one issue; when he tries to focus on one issue, he tends to become overwhelmed.
- Lack of energy and no desire to take on problems that really need to be addressed.
- Difficulty remembering things, which leads to missed appointments.
- Feeling like he has so many problems that he doesn't know where to start.

Troy remembered that his old behavioral health counselor was very helpful to him, so he called to see if the counselor could help him with his housing.

Setting

The counselor works in a community-based, multiservice substance abuse treatment organization. Some of the program staff members specialize in housing and employment assistance.

Learning Objectives

- Adapt counseling strategies to unique client characteristics and circumstances.

- Coordinate treatment and prevention activities and resources that suit client needs and preferences.
- Understand the interaction of co-occurring substance use and mental disorders with homelessness.
- Work with others as part of a team.

Strategies and Techniques

- Homelessness prevention
- Cognitive restructuring
- Working with persons who have co-occurring substance use and mental disorders and are homeless
- Interventions for substance abuse relapse

Counselor Skills and Attitudes

- Assess basic life skills and functioning.
- Recognize and address underlying issues that may impede treatment progress.
- Respond appropriately to the client's environmental stressors, employment situation, and childcare responsibilities.
- Accept relapse as an opportunity for positive change.

Vignette

Visit 1 (counselor's office)

The counselor has not seen Troy for 10 months and begins the first session with the following goals:

- Reestablish the working relationship.
- Identify the concerns that have prompted Troy to seek treatment.
- Understand the circumstances for Troy's relapse.

Troy arrives at the session looking down in the dumps, tired, and distracted. His speech is soft, and he is slow to respond to the counselor's questions. He appears to be having difficulty concentrating.

COUNSELOR: Tell me about why you wanted to see me.

TROY: Well, I dunno. Because I'm using a lot of weed and stuff. I been using it for a while; a lot of stuff's going down. I'm behind on the rent and it's really hard to keep up. It takes the edge off, you know?

COUNSELOR: Last time you were in, we spoke of coping with stress. Have you been using those skills?

TROY: A little bit. I've been trying to keep up with my kids and stuff.

COUNSELOR: All right.

TROY: I put the kids to bed at 9, and it's my time after that, you know.

COUNSELOR: Around what time do you go to bed?

TROY: It depends. Midnight, 1 o'clock. Sometimes the guys are over and we stay up a little bit late, you know, smoke a little, drink a little. But I'm so *tired* when I get up in the morning.

COUNSELOR: You're really tired in the morning.

TROY: [*affect is somewhat flat*] I have to get them to school. It's good that I do that, you know? Then I go home and… I messed up a couple months ago. I go to sleep sometimes after I drop them off, and I didn't show up to work, and now it don't even matter to me if I work. I got enough with the boys.

[Troy and the counselor spend a few minutes talking about his wife abandoning the family, his dropping out of AA, his relapse, and the loss of his job. Troy thinks his most pressing problem right now is the possibility of losing his home.]

COUNSELOR: Yeah, having children can be challenging—it's a new life that you have, right?

TROY: Yeah, I guess so. It just gets the better of me. I didn't know it was going to be like this.

COUNSELOR: I remember when you were in treatment; we talked in group one night about your fear that your wife might leave if you got clean. As I recall, you thought you were definitely the better parent for the boys and that, if she left, if you got custody of them, it might be good for everyone.

Master Clinician Note: The counselor empathizes with the challenges of single parenthood and reminds Troy how proud and excited he was to get his boys. This helps Troy to decrease negative self-assessment and increase his confidence in his ability to make a change. A key treatment effort in early recovery is to help clients increase self-esteem, improve self-confidence, and learn to evaluate the impact of their actions before they act.

TROY: Maybe. I just gotta get back to my house to just see the kids, I dunno.

COUNSELOR: Where are your kids now? In school?

TROY: They should be getting home any minute. I gotta leave here in just a few minutes.

COUNSELOR: Okay. I can see that you are under pressure to be there when they get home. Can you give me at least 5 minutes? Let's list what we talked about. You're worried about losing your apartment, it's hard managing the kids, and you've relapsed—is that correct?

TROY: Yeah, like, it's just not happening for me now. Sometimes I guess I get to the point where I just say, #*%! it. And, maybe that's why I smoke and I been drinkin'.

Master Clinician Note: The counselor empathically reflects Troy feeling overwhelmed, letting Troy open up more about feelings of hopelessness, irritability, and the role of substance abuse. Taking time to gather more information and develop rapport with the client before working on the problems the client and counselor have identified decreases client resistance to change.

How To Work With a Client Who Is Overwhelmed

Once you recognize that your client is overwhelmed with life problems or with the information you've shared in a counseling session, change your expectations for what you can accomplish in sessions until he or she is doing better:

1. Keep your sessions short (15–30 minutes).
2. Don't overload the client with information or tasks. Have realistic expectations based on the client's abilities.
3. Keep the information you provide brief; speak in simple, short sentences.
4. Offer assistance with accomplishing a task if the client isn't able to do it independently.
5. Create a list of urgent, important tasks; work to address those as the client is able.
6. Schedule brief sessions often during the week until the urgent, important tasks are done.
7. Monitor the client's body language, facial expressions, and responses for signs of overload. Offer to take a break or offer water to help the client be able to continue and feel understood.

COUNSELOR: So let's put that on the list of things we need to work on: the drinking and the weed, getting back into your AA program. We need to look into some emergency housing support until you can get back on your feet. Do you have any income now?

TROY: My brother sometimes has a little work for me; he's a contractor. But, you know, nobody is working in construction these days. So I hardly get enough to feed us.

COUNSELOR: Okay. Do you agree that these are the things we need to work on first: getting clean, going back to AA, getting you emergency housing support, and getting back to work?

TROY: Yeah. Well, I really gotta get out of here.

COUNSELOR: So, real quick, did you talk to your Section 8 representative?

TROY: Uh…nah.

COUNSELOR: Okay. Here's the representative's name and number; call her and say that you lost your job. They'll recertify your income, which will lower the rent you have to pay. [*The counselor writes down Sherri's phone number and a note reminding Troy to explain that he's lost his job.*] She'll be there until 6 tonight.

TROY: Uh-huh.

COUNSELOR: We can work together to help ensure that you won't lose your home. I have an

A Note on Section 8 Housing

Section 8 Housing is a voucher program funded by HUD. It assists very low income families in obtaining decent and safe housing in the private housing market. Once they are deemed eligible, participants find their own rental housing in their communities. HUD (through its designee in each State) then pays the landlord the difference between a specific amount (generally 30 percent of the of the tenant's adjusted income) and the fair market rent of the housing unit. Eligibility for participation is determined by the household's gross income, which generally may not exceed 50 percent of the median income of the county in which the family resides. Special programs are available for families with disabilities and to reunify families with children placed in foster care due to inadequate family housing. Involvement in drug-related or violent criminal activity is grounds for loss of Section 8 housing.

Source: HUD, n.d.

appointment available tomorrow at 11:30 if you'd like to come back.

TROY: I'll come tomorrow.

> **Master Clinician Note:** Troy has made some progress on his own getting food stamps, public assistance, and setting up an appointment for the visit today. The counselor recognizes these steps as strengths and hopes to build on Troy's ability to mobilize to get him back to AA and to help him focus on staying abstinent, developing stronger parenting skills, and getting a job. If the counselor gives him too much to do, Troy will feel overwhelmed and spiral downward, so he doesn't push these issues in the first visit. The two most pressing problems—from the counselor's perspective—are helping Troy regain abstinence and maintain his housing. Without abstinence, it will be challenging for Troy to attain the other goals of improving his parenting skills and getting a stable job. Without stable housing, the counselor suspects it will be difficult for Troy to maintain abstinence. He is also concerned about Troy's level of depression and decides to talk with him on his next visit about consulting with the staff psychiatrist.

[After the first meeting with Troy, the counselor follows up with the Section 8 staff, explaining Troy's concern about losing his housing due to unemployment and mentioning that Troy now has custody of his boys. The counselor and the Section 8 representative agree to work together to help Troy recertify his current rent, access a local rental assistance program to help pay his back rent, and engage in substance abuse treatment.]

Visit 2 (hallway outside counselor's office)

Troy doesn't make his 11:30 a.m. session, but shows up later on in the lobby. The counselor is between sessions with clients, so he talks to Troy in the hallway for a couple of minutes. Troy vaguely

How To Handle Late-Shows and Missed Appointments

How you address late-shows and missed appointments depends in part on the client's ability to plan and organize sufficiently to arrive on time:

1. If this is the client's first late-show or no-show, consider whether memory or concentration problems may exist that make it difficult for the client to remember appointments and arrive on time.
2. In the absence of cognitive problems, explain the importance of punctuality. Don't take the client into your office to negotiate; don't go out of your way to extend session time or reschedule (remove positive reinforcement). You may also give the client an appointment card, express regret that the client missed the appointment, and focus on what will be accomplished in the next visit.
3. If the client has cognitive problems, ask him or her to explain the tardiness and schedule another appointment. Don't take the client into your office to negotiate. Offer an appointment card to be kept in a wallet, or suggest putting it on the refrigerator.
4. If this is not the client's first late-show or missed appointment, and the client is tentatively engaged in services (e.g., client is chronically homeless, client's willingness to engage in services is itself a significant accomplishment), it may be unrealistic to expect punctuality. One effective approach that reinforces showing up is to allow the client to walk in and wait for the next available appointment.
5. If the client has been late or missed other appointments, but has shown the ability to be on time, then lateness or missed appointments may be a way of demonstrating ambivalence about the counseling process. Explore this briefly, as he or she walks in or calls, to enhance the relationship and make the client more likely to return. You can also express regret that the client missed the meeting and focus on what will be accomplished in the next visit.

remembered that he had an appointment but wasn't sure what time it was supposed to be—another indication of his difficulty with memory and his inability to focus. The counselor says there's an opening at 2:00 p.m. if he wants to wait. Troy agrees, and the counselor asks if he called the Section 8 representative. Troy hasn't, so he tells him to ask the receptionist to let him call while he's waiting. Troy finds it helpful to have this specific task to do while he's waiting.

The counselor meets with Troy at 2:00 p.m., but Troy announces that he can stay for only 15 minutes because he has to get his kids. The counselor's goals for these 15 minutes are to:

- Verify that Troy called the Section 8 staff and is no longer at immediate risk of losing his housing.
- Focus on connecting Troy with resources for getting clean and sober.
- Get Troy's cooperation in scheduling a psychiatric consultation.

COUNSELOR: So, what did Sherri say?

TROY: Sherri said it's all right. She gave me some information about a program I could contact for help paying the back rent. She did mention something about wanting me to stay in treatment, though.

COUNSELOR: Right. She said that you need to show that you're working on a plan for abstinence that'll help you keep your housing. You did a great job working with her; you must feel pretty good about that.

TROY: Yeah, okay.

COUNSELOR: So that piece is taken care of. There are a couple of things I want to talk to you about. First, I need you here on time for our meetings. We were scheduled for 11:30 today.

> **Master Clinician Note:** In situations when a counselor must rapidly change gears and abridge the content of the session (starting late and/or ending early), it is necessary to select simple priorities that can be accomplished in the time allowed. It is important to be clear with the client that the agenda is reduced specifically because of time constraints.

TROY: Well, you know, I got the kids to school, came back, had some stuff to do. I was tired.

COUNSELOR: What kind of stuff did you have to do?

TROY: I needed to sort of catch up on some sleep, and then I had some business to do.

COUNSELOR: You're sleeping more in the daytime.

TROY: You know, I've been sleeping a good bit. I gotta catch up on it sometime.

COUNSELOR: Sounds like you're exhausted. It's hard to get things done with a lot on your plate.

TROY: Uh-huh. I got a call from Jimmy's teacher. He's been getting to school late and they're talking about some meeting. She mentioned calling child welfare, and I gotta get out of here to pick them up. They get out at 2:45.

COUNSELOR: You sound worried. You're starting to get your life back together and be a good parent, and I can see you're very concerned about getting them on time. Can we spend 5 minutes going over a few things, and we'll get you out of here? I want to get back to that child welfare issue for just a minute.

TROY: Okay.

COUNSELOR: Okay. Well, we've got to make sure you keep your housing. That's a big priority. The other thing I think is important is your getting clean again.

TROY: Uh-huh. Well, I haven't used now in a couple of days. I haven't slept worth a damn, but other than that, it hasn't been too hard.

COUNSELOR: Okay. What do you need to keep on staying clean?

TROY: Well, I just need to keep on. I'll keep on seeing you, if you want. I gotta keep people out of the house after the boys go to bed. That's when it gets lonely, and I'm tired, and people drop over.

COUNSELOR: I want us to talk more about this, but I know you need to leave in just a minute, so I want to get back to the child welfare issue. When do you meet with the teacher?

> **Master Clinician Note:** The counselor would like to continue solving problems and building strengths with Troy to help him stay abstinent, but he recognizes that Troy has only a few more minutes left. He wants to return to the issue Troy raised of child welfare being contacted about his kids. The counselor also decides to forgo the issue of psychiatric consultation. He doesn't want to raise another issue, which might overload Troy. He respects Troy's need to get to the school on time and doesn't want to end the session on a possibly contentious note, should Troy decline to get the psychiatric consultation.

TROY: [*seems frightened*] Well, I guess 3 o'clock. I don't know what's going to happen.

COUNSELOR: You seem kind of frightened about what that meeting is about.

TROY: Yeah.

COUNSELOR: She may discuss the importance of them arriving on time or other things. I'll support you as much as I can. Call me if you want to talk about the meeting before our next session.

TROY: Okay.

Visit 3 (counselor's office)

The counselor has the following goals for this session with Troy:

- Have Troy accept a referral to the staff psychiatrist for evaluation of potential depression.
- Support Troy's abstinence and help him build strengths to continue to stay clean.
- Support Troy in taking action on behalf of his sons—for instance, by attending meetings at the school.

How To Manage the Stress of Seeing Clients Who Have Multiple Problems

Counselors have many responsibilities during and between sessions. It's frustrating to work with a client who has urgent problems and fails to show up for appointments or follow through with assignments. It's even more stressful when children are involved. How do you address these needs and avoid burnout?

1. Know the system and resources currently available in your area.
2. Help the client get access to these resources quickly.
3. Remember that you help clients handle urgent and important issues, but you're not responsible for their choices.
4. Resist the urge to rescue the client from his or her emergency and/or feelings of being overwhelmed; attempt to respond concretely to what is presented as an urgent need.
5. Remember that helping the client prioritize multiple needs is an important part of the work. Help the client create a list of the urgent, important things that need to be done and prioritize them.
6. Identify teammates who should be brought in (e.g., psychiatrist, Section 8 representative, child-care specialist).
7. Seek supervision frequently.

Troy arrives for the session on time. He still feels overwhelmed, very tired, and doesn't have much motivation to look for a job, but now has 7 consecutive days of abstinence. The session begins with Troy describing the meeting with the teacher and assistant principal of the school. The school authorities had not contacted child welfare but stressed that if the boys continued to act out at school and didn't arrive on time, they would have to take some action on behalf of the boys. The counselor supports Troy in staying clean and in addressing the needs of his sons. The counselor then decides to raise the issue of the psychiatric consultation to rule out depression.

COUNSELOR: Troy, I'm concerned that you seem tired all the time, overwhelmed, don't have much energy for doing things, and are having trouble concentrating. I think it would be good if we could get some consultation on whether or not you are depressed, and if so, what we can do about it. So, I'm wondering if we could schedule an appointment for you with Dr. Moore, our psychiatrist, to have you checked out for depression.

TROY: [*seems a bit helpless in attitude*] Yeah, I don't know. I don't wanna go see Dr. Moore. A friend of mine, when she went to see the psychiatrist, they took away her kids.

Working With Clients Who Are Homeless and Have Co-Occurring Disorders

A wide range of substance use and mental disorders can co-occur with homelessness. In most cases, homelessness makes treatment of and recovery from mental and substance use disorders more problematic, and the co-occurrence of substance use and mental disorders limits the person's ability to address critical life problems such as homelessness. It is imperative to treat all three conditions—substance use disorders, mental illness, and homelessness—concurrently using an integrated approach. For more information on the impact of CODs and homelessness, see SAMHSA's Homelessness Resource Center Web site (http://homeless.samhsa.gov/channel/co-occurring-disorders-457.aspx) and the SAMHSA Web site's section on CODs (http://www.samhsa.gov/co-occurring/).

In the following sessions, observe how the counselor and Troy work together to obtain a psychiatric evaluation of Troy's depression, implement treatment for this condition, support his recent abstinence, continue his attendance at AA, and help him maintain secure permanent housing through the Section 8 housing program.

Master Clinician Note: The counselor resists assuring Troy that meeting with the psychiatrist won't cause his kids to be taken away. It is important that the counselor never promise outcomes that are out of his control. The counselor can support the client (as shown here) to take constructive action to obtain a positive outcome.

COUNSELOR: I know you're reluctant to see Dr. Moore, but I'm concerned about how stressed you are. This may affect keeping your home and your kids. Meeting with Dr. Moore could help with that.

TROY: Yeah. Okay. When do I need to go?

COUNSELOR: I'd like to get you in as soon as possible. I'll call and see if there's anything on Monday morning or, if not, as soon as possible. Okay?

TROY. All right. When will I know?

COUNSELOR: I'll call now. Give me a couple more minutes.

[The counselor calls and arranges the psychiatric consultation for the following Tuesday morning at 10 a.m. After passing along the information to Troy, he engages Troy in problem-solving about staying abstinent, not having friends over late at night, not being around people who are using, being especially careful during times when he is feeling stressed or hopeless, and particularly, going to AA again. Troy engages in the problem-solving efforts with the counselor, and the counselor helps Troy identify strengths to address each of these issues. He is reluctant to return to AA; he says he quit going because his sponsor was putting too much pressure on him to complete his work on the program steps and because his best friend in the program had "gone out," which Troy found really discouraging. He did agree to a noon meeting later in the week, while his boys were in school. Troy also agreed to ask his mom, who lives in the neighborhood, to babysit while he attends a meeting on Saturday night. The counselor and Troy talked about how he would respond if he ran into his program sponsor, and they developed several options for this scenario.

The counselor continues to be sensitive to Troy's potential for becoming overwhelmed with too many issues and defers other issues (parenting, employment) until future sessions.

In closing, he reinforces Troy's assignments of not being around people who are using, not staying up late at night (even if he is not sleepy), staying abstinent, and attending AA. Together, they make a list of things Troy is to do and behaviors that will make it easier to accomplish them.]

How To Use Assignments Between Sessions

Assignments between sessions are a useful tool in counseling. They help learning carry over from the session into daily life and put what has been talked about in the session into action. Assignments also make change a part not just of counseling, but of everyday life, and they keep change as an "up-front" activity in the client's mind. When giving assignments, it is useful to:

1. Make sure the tasks are attainable in the time period of the assignment and, to the extent possible, can be repeated several times during the assignment period.
2. Try not to overload the client with too much to do, so the task does not seem overwhelming.
3. Make tasks behaviorally specific and measurable, a "to-do" rather than a "not-to-do" list.
4. Have clients record their successes and difficulties in achieving the tasks.

Visit 4 (counselor's office)

The counselor's goals for this session are to:

- Follow up on Troy's psychiatric consultation.
- Follow up on how abstinence is progressing.
- Check on how Troy is doing with his sons.
- Ask Troy about his plans to resume employment.

Troy arrives on time and looks somewhat less distressed and tired than he has on previous visits. He reports that his visit with the psychiatrist went well and that he liked Dr. Moore. The doctor had already reported to the counselor that he thought Troy's difficulties in focusing on tasks, not sleeping, feeling overwhelmed, and not thinking clearly were more a function of stress and alcohol and drug use than depression. He did not recommend medication but suggested that he would be glad to reevaluate Troy if he continued to have difficulties in thinking, feeling overwhelmed, or completing tasks. For more information on depression and substance abuse treatment, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT, 2008). The session continues as Troy talks about a meeting with the teacher of his 8-year-old son, Jimmy.

TROY: I had another meeting with Jimmy's teacher.

COUNSELOR: How did that go?

TROY: Well, he's having some anger problems in school, and he's been getting there late. Actually, both of them are getting there late.

COUNSELOR: Tell me about that.

TROY: Well, they take a long time to get out of the house. They aren't exactly cooperative all the time, you know? It's hard to pull 'em out of bed in the morning; I oversleep a little bit myself.

COUNSELOR: Okay.

TROY: I talked to Dr. Moore a little bit about it, and he said that maybe you guys could help.

COUNSELOR: There are some things we can do to help. For example, you said sometimes you guys oversleep. We can work out a better way to manage that.

TROY: Okay.

COUNSELOR: What time are they supposed to be in school?

TROY: They gotta get there at 8:30.

COUNSELOR: Okay, 8:30. What time were you getting them up when they were getting there late?

TROY: I don't know. I'd try to get them up around 7, but they'd get up at 8 or so.

COUNSELOR: It does take them a while to get ready for school, and they have to be there at 8:30. How far is school from your home?

TROY: About 15 minutes.

COUNSELOR: 15 minutes. So, you're going to need to have at least 15 minutes to get them to school. What else do you do in the morning before leaving for school?

TROY: Well, they eat breakfast, usually cereal. I try to get them up around 6:30 or 7.

> **Master Clinician Note:** The counselor's technique is called cognitive structuring. He uses questions to model and encourage problem-solving about how Troy can more satisfactorily manage his time. The counselor also distinguishes Troy's intention (waking at 7:00 a.m.) from the reality (waking at 8:00 a.m.).

COUNSELOR: So let's say you get them up at 7:00. You need 15 minutes to get to school, so that leaves an hour and 15 minutes to dress and feed them. Can you do that?

TROY: I can do it.

COUNSELOR: So, can we make a plan for that? Today is Wednesday, so for 2 more days of school—

[The counselor writes up a schedule for Troy to follow in the morning. Troy reads it and agrees that he will try it out. Troy then changes the subject to his kids.]

TROY: I get a real hassle from the boys. They fight me, and they fight each other.

COUNSELOR: What do you think they need?

TROY: Oh, I don't know. I guess I fought with my brothers every day when I was a kid, too.

[The counselor continues to explore the issue of the children's behavior with Troy, and they decide that if things don't get better in a month or if things get worse in the interim, they'll look into counseling options for the boys. The counselor is reluctant to jump right into seeking counseling for the boys, expecting that things might get better if Troy stays abstinent and the home situation stabilizes.]

COUNSELOR: Troy, I would like to raise the possibility with you of having the boys participate in some after-school activities at the Boy's Club right down the street from our center. They have a bunch of good programs, including sports, helping them with homework, and giving them some time to socialize and play with other kids. Plus, it would give you some extra time away from having to watch the boys to get some stuff done. So, I'm wondering if you would be willing to drop by there and see what is available that might be right for your boys and consider it.

TROY: Well, I could do that. I know where it is; I used to walk by it every day. I never knew what they did in there, other than play basketball.

COUNSELOR: Well, actually, they do a lot of things, and some might be helpful to you and to your boys.

TROY: Okay, I'll look into it.

Brief Strategic Family Therapy

If the children continue to show behavioral problems in school, the counselor might consider adapting an evidence-based practice, brief strategic family therapy (BSFT). Although Troy's sons are a bit younger than the typical age when BSFT is applied, it might prove helpful.

BSFT is designed to (1) prevent, reduce, and/or treat adolescent behavior problems, such as drug use, conduct problems, delinquency, sexually risky behavior, aggressive/violent behavior, and association with antisocial peers; (2) improve prosocial behaviors, such as school attendance and performance; and (3) improve family functioning, including effective parental leadership and management, positive parenting, and parental involvement with the child and his or her peers and school. BSFT is typically delivered in 12 to 16 family sessions but may be delivered in as few as 8 or as many as 24 sessions, depending on the severity of the communication and management problems within the family. Sessions are conducted at locations that are convenient to the family, including the family's home in some cases. Hispanic families have been the principal recipients of BSFT, but African American families have also participated in the intervention.

BSFT considers adolescent symptomatology to be rooted in maladaptive family interactions, inappropriate family alliances, overly rigid or permeable family boundaries, and parents' tendency to believe that a single individual (usually the adolescent) is responsible for the family's troubles. BSFT operates according to the assumption that transforming how the family functions will help improve the teen's presenting problem. BSFT's therapeutic techniques fall into three categories: joining, diagnosing, and restructuring. The therapist initially "joins" the family by encouraging family members to behave in their normal fashion. The therapist then diagnoses repetitive patterns of family interaction. Restructuring refers to the change-producing strategies that the therapist uses to promote new, more adaptive patterns of interaction. For more information, see the BSFT Web site (http://www.bsft.org).

COUNSELOR: Troy, I just want to be sure your rent situation is taken care of for now. Where do we stand with that?

TROY: Well, I think it's okay. I have emergency assistance that has paid what I owed for the past 2 months, and I'm current now. Section 8 housing has reduced my rent because I'm unemployed, but, you know, this #*%! public assistance doesn't really pay for crap. I got these two kids I gotta keep going. I'm not a rich man! I'm just not making ends meet.

COUNSELOR: Do you think you're ready to look for a job? You think you can handle that right now?

TROY: I don't know if I want to go back to work right away, because then I got a problem on the other end; we sometimes work until 6 at night. What are the kids gonna do for 3 hours?

COUNSELOR: Okay, let's work on child care if you need that. We need to make a plan that'll help you in the long run, so when you work and can't get home on time, the boys will still be cared for.

TROY: Does that mean they're gonna take the kids away from me?

COUNSELOR: No. This is all about helping you. We have a temporary childcare program here that will help you for up to about 2 months. That's the longest they will help you. It allows us to develop a plan for you. One option is for your mom to keep the boys in the afternoon. We did talk about your mom; you were concerned about the money you owed her.

TROY: [*worried*] Yeah. We're not talking much.

COUNSELOR: Tell me about when you were being raised up. Did you ever do anything that may have upset your mother? Like miss school, and she caught you, and she was upset about it?

TROY: Yeah. Well, we had our days.

COUNSELOR: And after those days happened, was your mom still talking to you?

TROY: Yeah. Yeah. I mean she's—yeah, she's all right.

COUNSELOR: So she continued to talk to you?

TROY: [*sounds anxious*] Yeah, but like, you know, I'm trying to do the best that I can. I gotta show her that I'm doing my thing, but I owe her all this money.

COUNSELOR: Do you think she would be proud of your being able to take care of a lot of the things you have taken care of, like your housing?

TROY: Yeah. Yeah. I see where you're going with this. I still feel kinda uncomfortable. You know, I don't feel so good about this, but maybe, maybe…

COUNSELOR: Okay. Let me ask you this. Let's practice for a few minutes what you might say to your mom and how she might respond. Then, what if you called your mom from here at the office to see if you can make some headway in how y'all get along. Do you remember how we did role-play when you were here in treatment?

TROY: Sure, I'd go with that.

COUNSELOR: Okay, let's start with you being your mom, and I'll be you. And talk to me, as if I'm Troy, about how you feel about me and how things have been going. I want you to really listen to your mom, see what she says. You may be surprised; she may be supportive, strong, and not worried much about the money. And I want you to hear what her concerns are about how you are doing and what she expects of you.

> **Master Clinician Note:** Role-play is an excellent counseling resource for helping clients prepare for difficult interpersonal situations. A description of how to set up a role-play and how it can be used is presented in the next vignette (René).

[Troy and the counselor proceed to role-play an interaction between Troy and his mom. Afterward, Troy believes that he understands more of where she is coming from and can more comfortably talk with her about the money he owes her and about her helping with child care.]

COUNSELOR: Let me change the subject for a minute and ask you how you are doing with not drinking or smoking weed.

TROY: Well, I had one beer the other evening, standing around outside with some other guys, and then I got to feeling bad about it. I had 9 days put together. But I know from here and AA that a beer is a beer. But that is all I've had, and no dope now for almost 2 weeks.

COUNSELOR: What about AA?

TROY: I've been twice, both to noon meetings because I didn't have anyone to watch the kids. I didn't see my old sponsor either time. I guess when I run into him, we'll have to get straight with each other.

[The counselor and Troy continue to talk for a few minutes about the need to remain clean and sober. They discuss the people, places, and things that might provoke a return to use. The counselor is supportive of Troy in finding alternatives to drinking or smoking marijuana.]

COUNSELOR: Okay. I appreciate all the hard work you've put into this. I think you've done a lot. I think you've made some positive changes. Do you agree with that?

TROY: So far, so good.

COUNSELOR: Okay, so what if we continue to meet once a week? If and when you get your roofing job back or another job, we'll look at how we can arrange counseling around your schedule. I remember that Carl often lets people take off an hour or two around lunch if they are going to a counseling session. And I think we have goals and priorities pretty set now: staying clean, keeping your housing, helping the boys get settled, handling stress and life problems, managing your finances, and getting back in good graces with your mom. Does that pretty well handle it?

TROY: Well, I'm better off than I was a month ago, that's for sure.

Summary

Troy experienced a number of significant stressors that were aggravated by marijuana and alcohol abuse and his difficulties in coping with stress. On presentation, Troy was in the action stage of change for keeping his housing and his kids and the contemplation stage of change for drinking and marijuana use. The counselor used a variety of techniques and multidisciplinary tools (for instance, consultation with the staff psychiatrist, referral to AA, supportive problem-solving, cognitive structuring, and role-play) to help Troy move ahead in the stages of change for addressing his marijuana and alcohol use and other life difficulties. Future sessions will focus on child care, improving parenting skills, preventing relapse, and maintaining his job. Long-term goals include helping Troy:

- Maintain stable housing through the Section 8 voucher program.
- Reduce his negative thinking and increase his hope and planning for the future.
- Maintain contact with his family for help with child care and recovery activities.
- Identify funds that he can use to pay his mother for helping with the kids.
- Identify after-school programs so his children can stay at school while he's working.
- Support stable continuation of recovery using agency resources and self-help programs.
- Continue to develop effective coping and parenting skills, problem-solving abilities, and stress management techniques.

Vignette 5—René

Overview

René is in the transition planning/ongoing homelessness rehabilitation phase. This vignette demonstrates approaches and techniques for substance abuse relapse prevention.

René is a 44-year-old man in intensive outpatient (IOP) treatment for heroin dependence. He relapsed once during treatment but recovered and got back on track quickly. His treatment program ends in 3 weeks, and he needs a new place to live—his current apartment is attached to the program. The stress of the impending transition contributed to his relapse. René used heroin after his last paycheck, but he did keep his job. He has a history of intermittent homelessness. His job doesn't pay well but offers benefits. He's a good fit for a sober living facility, which offers quality housing and social and abstinence supports.

Setting

Working in a substance abuse treatment organization's intensive outpatient program, the counselor offers case management and counseling services for transition into ongoing homelessness rehabilitation services and independent housing.

Learning Objectives

- Use counseling methods that support positive behaviors as objectively defined goals consistent with recovery and stable housing.
- Help client identify and change behaviors that are not conducive to meeting objectively defined recovery goals.
- Teach the client relapse prevention and life skills.

Strategies and Techniques

- Conceptualizing behavioral change activities oriented toward substance abuse recovery as therapeutic goal management
- Coping skills training conceptualized as short-term goals agreed to with clients to accomplish longer-term sustained behavior change

Counselor Skills and Attitudes

- Recognize and address underlying problem behaviors that may impede the client's recovery and housing stability.
- Facilitate the client's identification, selection, and practice of strategies, especially goal attainment, to sustain the knowledge, skills, and attitudes needed for maintaining recovery and housing.
- Recognize the importance of continued support, encouragement, and use of reinforcement and contingency management.

Vignette

Visit 1 (counselor's office)

The counselor has worked with René throughout his time in the IOP program. He's abstinent but nervous about the future. The counselor begins the first session with these goals in mind:

- Conceptualize René's recent relapse.
- Encourage him to increase his attendance at Narcotics Anonymous (NA) meetings.
- Discuss his housing options.

The counselor greets René and asks how he's been. René is in a tough spot, having relapsed while preparing to transition out of the program. If he didn't trust the counselor, he might respond with "I'm okay, I can deal with it," but they have good rapport. René believes she'll help him, so he offers an opening for help.

RENÉ: Man, life has been crazy. Working on that bull#*%! job, it ain't payin' nothing. I really don't have no clue what I wanna do in about 3 more weeks. My girl, she's trippin'.

COUNSELOR: It's a lot. I mentioned a halfway house and a sober living facility as steps toward building some quality sober time. What do you think?

RENÉ: I don't know about that #*%!. I want my *own* spot, you know?

COUNSELOR: I understand that you'd like your own apartment, and I hope we can work toward that.

RENÉ: #*%!, it don't make no difference! I don't make enough money. I don't know what I'm gonna do.

COUNSELOR: Well, would you be able to accept the goal of moving to a halfway house, and then, when you have another 60 days under your belt, we can talk about moving into a sober living house? We could talk about how you'd deal with that time in the halfway house.

> **Master Clinician Note:** The counselor should be aware of local housing options, including single room occupancy housing, shelters, halfway and transitional living houses, sober houses, Housing First, and other community housing opportunities. Each meets a specific housing need, and all have unique requirements for participation. Some have no financial requirements; some, such as sober housing, involve a fixed monthly rent based on ability to pay; and some require an agreement to pay a percentage of earned income. Some have no requirements about drug use or maintaining sobriety, but others require abstinence from alcohol and any illegal or illicit drugs. Some are for relatively short periods of time and others are ongoing. Each meets a unique need in the community.

RENÉ: I don't want that #!*%!. I had lots of time in that kind of by-the-rulebook living. I guess it's my fault, but I ain't making no money on that job.

COUNSELOR: You're thinking it's your fault? This situation?

RENÉ: Yeah, 'cause I been shooting dope for a long time. This #*%! may not even work for me. I probably waited too long, you know?

COUNSELOR: Well, René, I really hope you will work toward getting your own place.

RENÉ: Aw man, that #*%! is crazy. I'm tired of living with other people. You *know* how them places are?

COUNSELOR: You've done really well here. Except for that relapse, you've managed to use the program to your advantage. Can you allow yourself to feel good about that?

How To Help a Client Identify Triggers for Relapse

Working on relapse prevention is a good way to help many clients maintain housing. Identifying triggers is one way to start, and this can be done in several ways. Be respectful and kind; this conversation tends to evoke shame in clients:

1. Open with, "Tell me about what happened the last time you relapsed." The point is not to get a list of the triggers your client already knows about, but rather to really understand what happened this time.
2. Ask the client to look back in time to identify each choice point that led to the relapse.
3. Keep going back until you reach the point where the client veered from the recovery pathway into relapse. The choice point may be earlier than the client thought, or it may be a feeling he or she is reluctant to talk about. If it's a feeling, identify the thought that led to the feeling.
4. Help the client brainstorm and practice ways to handle the situation or feeling the next time. Role-play helps clients practice coping skills and develop a sense of mastery. It also increases self-esteem and provides further motivation to continue the recovery process.

For more information on identifying and addressing triggers, see the planned TIP, *Recovery in Behavioral Health Services* (SAMHSA, planned e).

RENÉ: Yeah! I'd never been clean very long before, so I'm real happy about that. But I think maybe this is the best it's gonna get for me.

COUNSELOR: If this is the best it's gonna get for now, let's talk about how you'll handle it.

RENÉ: #*%!. I don't know how.

COUNSELOR: Well let's talk about that relapse you had. What happened? I'm sure you've reviewed this in your treatment groups. We talked about this before, but let's just go over it again.

RENÉ: It was kind of a blur. I got off work and those dudes wanted to go out. They act stupid every time they drink, so I didn't wanna go with them. I was walking back to my place thinking about all this stuff that's going on, and I seen Cheryl and we started kickin' it. Next thing I know, I'm shooting dope.

COUNSELOR: So you got paid, you saw your girlfriend, and sort of went off.

RENÉ: Yeah. Now that I think about it, I can't remember many times that I've had sex without using. Maybe I don't think I can perform without dope. I don't know how, but that #*%! comes together for some reason.

Master Clinician Note: René has had this trigger for a long time. It's important to address it because it's a powerful trigger for relapse. The counselor can reflect what he's struggling with, ask about how he can be helpful, and go back farther to identify relapse triggers that happened earlier than this one.

COUNSELOR: So the main feeling that you're working toward is that feeling you have when you're high and having sex? So it's hard to imagine life without that?

RENÉ: Yeah. I guess so. That could be it.

COUNSELOR: Have you had sex with your girlfriend without being high?

RENÉ: Yeah, a couple times.

COUNSELOR: And how was it?

RENÉ: We really couldn't do the #*%! that I'm accustomed to doing, you know?

COUNSELOR: Um-hum. Was she high?

RENÉ: Yeah.

COUNSELOR: She was high and you weren't.

RENÉ: I wasn't. You can't really enjoy yourself or have the fun you wanna have, so you need something else to help you really enjoy it. Then you add on top of that the #*%! I'm going through. It could be one of a thousand things. It could be that I'm about to be homeless. Maybe that's it, and I don't wanna do that #*%! no more. I know when I'm loaded I can hustle and get some money and take care of my business.

COUNSELOR: So it's pretty hard to find a substitute for that, and yet you have just said the fear of being homeless again almost is enough for you to imagine you can give it up.

RENÉ: Yeah, the thought of that alone makes my stomach hurt. Have me where I can't breathe. You're asking me to see 6 months down the road. That's too long. Everything I do, I need immediate results, *immediate*. I go steal something, immediately I sell it. So waiting 2 weeks for my check, I'm struggling with that, because for years, I didn't have to delay nothing. And relationships—the first thing that I'm gonna do is get in a relationship, but in treatment and self-help groups, they tell you not to.

COUNSELOR: So, René, is it fair to say the first thing you want to do is enjoy yourself?

RENÉ: Yes.

COUNSELOR: The first thing you want to do is have fun, and right now, it's the old ways of having fun that you're thinking about. You're not aware of the new ways.

RENÉ: I don't know any new ways of how to really enjoy myself.

How To Help Clients Appreciate the Progress They Have Made

You can help clients like René, who are mired in feeling one step away from homelessness, see how far they have come (general strategies applicable to all clients are followed by specific examples taken from René's case):

- Elicit information about the changes they've made in their lives (e.g., by asking René, "What makes this temporary move different from all the other moves you've made in the past 20 years?").
- Shift focus (e.g., by saying to René, "Let's think of some things you could do that wouldn't lead to meeting Cheryl and getting high.")
- Reinforce recognition of triggers and insights (e.g., that René is scared about becoming homeless and having so much going on); unlocking triggers will help clients along the road to recovery.

The goal is to boost clients' self-confidence, which will continue to rise as they put together additional successes.

COUNSELOR: I understand it has been a long time since you enjoyed much of anything without being high. I'm wondering if there is anything you have enjoyed here in the treatment program—the groups, visiting with other people, helping someone out, something like that.

RENÉ: Man, that ain't FUN. That's just hanging out.

COUNSELOR: So it seems like things have to be high energy, high excitement to really be fun.

RENÉ: Maybe so. Otherwise it just seems boring. Like living in a damned halfway house or something.

COUNSELOR: Could we look for a minute at what would be fun that isn't bad for you in the long run?

RENÉ: Man, I don't know.

COUNSELOR: Well, it seems like we've raised several issues to work on here over the long haul. The first is how to have fun without it having to be high energy or high risk. The second is how to have some high-energy fun sometimes without getting into stuff that is destructive for you, like getting involved with drugs or maybe with Cheryl. The third may be to recognize when you are having fun and enjoying something that's just an everyday thing.

RENÉ: Man, that's high-level #*%!. I'm not sure I'm ready for that stuff.

[The counselor is satisfied to have raised the issue of how René conceptualizes having fun for right now. René has given a clear message that he is ready to change the topic. The counselor respects René's wishes and moves on to another topic raised by René earlier.]

COUNSELOR: Well, you said that the worst possible thing is to become homeless again.

RENÉ: Yeah, I know once I become homeless, I'd probably be going crazy. I lose my place, I go back on the street, I shoot dope and end up back in prison. And the nights are very scary.

COUNSELOR: You have been in this program for several months, and you haven't relapsed.

> **Master Clinician Note:** This is an example of strengths-based counseling: the counselor affirms René's strengths, eliciting that one of his strengths is the ability to derive support from his counselor and people in recovery. This, in turn, supports René's adaptive coping mechanisms.

RENÉ: Well, I don't wanna go back to prison. And then I was able to talk to you and the people in treatment. I have them for support, so…

COUNSELOR: So that is one way you helped yourself out of homelessness. [*René is looking away.*] I feel like I'm losing you because you're looking away. Can you look me in the eye?

RENÉ: Yeah, that's kinda hard.

COUNSELOR: Why is that kind of hard?

RENÉ: Uh…

COUNSELOR: Is it hard because I'm female and we're talking about intimate things?

RENÉ: [*tearful*] Well, I don't feel good about it, you know. I'm supposed to be way past this, but it seems like I'm just spinnin' my wheels. I'm not getting anywhere.

> **Master Clinician Note:** The shame that René is feeling can be challenging to a counselor. In this case, the counselor stays with it long enough to let René feel it. Then she reframes it as progress and helps him look forward to what he wants to do. As with all interventions, it is important that this intervention be handled in a culturally appropriate manner.

COUNSELOR: I'm hearing that you've come a long way and that you've had an idea now about what are probably some of your most difficult triggers, but you've got your finger on it.

RENÉ: Well, what's that?

COUNSELOR: We're talking about Cheryl and payday and when she calls. And also about fearing homelessness and getting fearful and then wanting to go out and use. I think you understand that it's what you have to do to get to where you want to be. You think to yourself, "I didn't like relapsing. I don't want to be homeless again." And yet here's this temptation in the form of your girlfriend. So what else can you do on payday when she's calling?

RENÉ: I need to quit that. That's for #*%! sure. If I wanna get myself in my own apartment, I'm gonna have to struggle with that, to not hang out with her.

COUNSELOR: So, how are you going to tell her? Or are you going to tell her that?

[They discuss whether and how René will be able to make a break with Cheryl.]

COUNSELOR: Well, how about trying that. Just not call her and not see her. Do you think that'll work? Can you give it a try and we'll see how it goes?

RENÉ: Yeah, maybe. I'll give it a try.

COUNSELOR: Now, what about these friends? The guys out on the street that hang out and want you to join them. We've talked a lot about that all through the program. It's real hard to hang out on the corner with all those guys who are high and not use.

RENÉ: Really, my friends are all in prison, so, it's hard for me to make friends. I probably need to try and meet some other friends. I really don't like the guys at NA. They're like, "You can't do this, you can't do that." I wanna be able to do everything anybody else does.

COUNSELOR: Well, if you're going to stay clean, you're going to need a good support system. You're talking about doing something that's difficult. It's payday, and you're trying not to have any contact with your girlfriend. There are people hanging around saying they want to be your friend because you've got a paycheck.

RENÉ: Yeah.

COUNSELOR: So, what other people are there—people to hang with and have a good time with who won't point you in the wrong direction?

RENÉ: You know, I really don't have any fun with nobody but people that are active users.

COUNSELOR: Are you going to meetings?

RENÉ: Yeah, I go to meetings.

COUNSELOR: How often do you go?

RENÉ: About 3 times a week.

COUNSELOR: What would you think of increasing that?

RENÉ: Honestly? Yeah, I know I need to go more. My sponsor tells me I need to go more.

COUNSELOR: How often does your sponsor say you need to go?

RENÉ: If you asked him, he'd say 7 days a week.

COUNSELOR: That sounds like it might be a good idea.

RENÉ: That's way too much. It's bad enough sittin' in those meetings. But, that could be an option. It's only an hour. So, how about this halfway house you were talking about?

COUNSELOR: Well, it's warm, it's got beds, meals, a bunch of guys who aren't using on site. It's not treatment, everybody takes part in taking care of the house, and if you're interested, they can help with things like getting a better job. It's not treatment, but it's a safe place for another 30 or 60 days; after that, we can maybe get you into a sober living house.

RENÉ: How long would I have to stay there in sober living before I get my own place?

COUNSELOR: Well, it is going to be a while, probably at least a year or two, before you have a steady income and are back on your feet. You want to go by and check it out?

RENÉ: I guess we can go by and take a look at it.

COUNSELOR: I think the other thing we'll do is to plan to meet pretty often between now and your discharge time a couple weeks from now.

RENÉ: Yeah, that would be good, because I have more of a relationship with you than I have with anybody else. I feel comfortable talking to you about these kinds of things.

COUNSELOR: When is payday?

RENÉ: Uh, next week.

COUNSELOR: So, let's start with that day. What do you want to happen?

RENÉ: I really don't know.

COUNSELOR: What did you say before? Let's talk about how it can be different from other paydays.

[René and the counselor create a plan for payday, which includes avoiding Cheryl, buying something with his money so he won't be tempted to use it to buy drugs, and going to the movies and

getting something to eat as a fun, substance-free recreational activity. René agrees to consider staying at a halfway house after he leaves the IOP housing, to attend sessions three times a week, and to continue to give urine screens.]

Visit 2 (counselor's office)

René had an insight about why he has been stuck and risking relapse, and he seems ready to try out some ways to avoid further relapses. The counselor has the following goals:

- Review how René handled the weekend.
- Assess his current ability to effectively manage high-risk situations like running into his ex-girlfriend.
- Practice refusal skills and other appropriate skills as needed.

The counselor asks René about payday; he says he didn't see Cheryl. He bought a cell phone, got some food to eat, and saw a movie. The counselor reinforces this achievement and asks René to tell her about it.

RENÉ: Well, it was a lot of work, because I was thinking about it the entire night before. I was thinking about what I was gonna do when I get my check and how I was gonna do it, so it wasn't easy. How not to go see Cheryl, what if I do see her? The more I tried not to think about seein' her, the more I thought about seein' her. So, it was good we talked about it in advance, because it was a struggle not goin' into the store to cash my paycheck. But, I went to the cell phone store instead. I kept telling myself, "Hey, look, I'm goin' to get me a cell phone, you know, and that's what I'm gonna do."

COUNSELOR: Did you have the thoughts of being homeless, being back in jail?

RENÉ: No, because if I have thoughts about that, I'd have to see Cheryl.

> **Master Clinician Note:** The counselor notes the connection between Cheryl as a relapse trigger leading to René's being homeless. She decides not to present this to René right now because it would lead their discussion in a different direction. The counselor wants to stay focused on managing high-risk situations, building refusal skills, and building other strengths.

COUNSELOR: Okay, so, the fact that you got through that day is very commendable. And now it's about having more clean time, building that into the future.

RENÉ: Yeah, it kinda put it into perspective—one day at a time.

COUNSELOR: I think we do need to deal with the fact that your ex is going to try to find you.

RENÉ: Yeah, I'm sure she is. Matter of fact, I know she is.

COUNSELOR: So, in a couple more days, you're getting another paycheck, and this time she's going to say, "I'm not letting that guy avoid me this week!" So I thought maybe we should play it out a little bit. So, can you put yourself in her shoes and pretend you're her?

Master Clinician Note: In this situation, role-play can help René experience the immediacy of feelings he will face when he sees his ex and rehearse a plan to manage these feelings while interacting with her. The counselor and René will role-play twice. The first time, the counselor will play René and model behavior. The second time, René will be himself in the role-play. René is already familiar with role-plays because they use them in the treatment program. When introducing role-playing for the first time, you should expect that the client may feel silly or uncomfortable. Reinforce communication of this discomfort and provide an explanation for the purpose of the role-play. For more information about conducting a role-play, refer to the planned TIP, *Recovery in Behavioral Health Services* (SAMHSA, planned e).

RENÉ: Yeah, because she's been bullyin' me for a while.

COUNSELOR: Okay, so we're going to take ourselves to the store. Okay, the usual thing that happens is you have the check, you go to the store.

RENÉ: Cash my check. Get me an iced tea and a couple of scratchers.

COUNSELOR: Okay, and there she comes. She pops in. So, I'm going to be you and you're going to be Cheryl. Okay?

RENÉ: Okay.

COUNSELOR: So here I am as you, I've got my check and I buy my tea and scratchers, and I'm heading out to figure how to use that cell phone better and think about a movie, and there you come. Go ahead.

RENÉ/CHERYL: Hey, René, what 'cha doin'?

COUNSELOR/RENÉ: Hey, Cheryl, just, uh, mindin' my own business. Just gonna go hang out.

RENÉ/CHERYL: Win any money on that scratcher?

COUNSELOR/RENÉ: No, not this time.

RENÉ/CHERYL: Well, you gotta be in it to win it. You win a million dollars, what 'cha gonna do?

COUNSELOR/RENÉ: Get as far away from here as I can.

RENÉ/CHERYL: Gonna take me with you?

COUNSELOR/RENÉ: Cheryl, I gotta live my life without you. I can't have you in my life. I know that you didn't see me last weekend and you probably thought, "Well, he forgot about me this week," but you can't go with me any longer.

RENÉ/CHERYL: Quit playing, René. #*%!, you know you love me.

COUNSELOR/RENÉ: I can't do it, Cheryl.

RENÉ/CHERYL: You *know* you like me!

COUNSELOR/RENÉ: Can't do it, Cheryl.

RENÉ/CHERYL: Ain't *nobody* gonna treat you the way *I* treat you.

COUNSELOR/RENÉ: I like the way you treat me, Cheryl, but I can't go back down that road. Seeing you, I see drugs, I see love, I see sex, I see disappearing into some bedroom with you. I'm never getting back from there, or goin' in there with you again.

RENÉ/CHERYL: Well, what do you want me to do? Maybe I don't want to live my life without you. Did you think of that?

COUNSELOR/RENÉ: I gotta take care of myself. I don't know whether I can tell you what you can do for yourself, but I know for myself that you gotta get out of my life, and I gotta get you out of my life.

RENÉ/CHERYL: [*forlorn*] Look, I feel lonely, baby.

COUNSELOR/RENÉ: I'm going. I'm gonna go back to that telephone store, I'm gonna learn how to work this thing, I'm gonna pick out a—

RENÉ/CHERYL: Oh! so you think you're too good for me now! *You* go to a treatment program, *you* get on this high-ass horse; *you* get a few dollars for bus fare, and now *you* too good for me!

COUNSELOR/RENÉ: No, I don't think I'm too good for you. I just can't be this close to you anymore.

RENÉ/CHERYL: You talk that #*%! about you care about me, and all that!

COUNSELOR/RENÉ: I'm done. I'm gone.

> **Master Clinician Note:** The counselor models imperfect responses and struggles a bit so the client doesn't end up thinking "I could never do that!"

[The first role-play ends, and the counselor and René return to being themselves.]

COUNSELOR: Okay, René, how did you think that went, that little exercise that we just did?

RENÉ: I see she really don't care about me. She's just an addict. When she said "you think you're better than me," I believe that I'm better than the dope game. I work hard not to be a dope fiend, so, yeah, I'm better than her.

COUNSELOR: Okay, well, you gave me a hard time during that. It was tough to walk away.

RENÉ: Cheryl would probably create a scene in that store, and I probably would have had to leave—that's the only way you can deal with it.

COUNSELOR: Okay, how about we reverse it now, and I'll be Cheryl, and you be yourself.

RENÉ: All right.

COUNSELOR: So, you're coming out of the store, and here I come.

COUNSELOR/CHERYL: Well, hey there, René, where ya been?

RENÉ: Hey, what's up, Cheryl, how ya doin'? I don't have time, girl, I'm on my way. I gotta go.

COUNSELOR/CHERYL: Hey, you know, you dissed me last week. I didn't like that very much.

RENÉ: I ain't never dissed you.

COUNSELOR/CHERYL: Did you miss me?

RENÉ: No.

COUNSELOR/CHERYL: Aw, come on now!

RENÉ: Cheryl, you don't give a #*%! about me; all you interested in is dope and I—

COUNSELOR/CHERYL: [*cooing*] You know I love you, you know I love you.

RENÉ: Would you love me if I was broke?

COUNSELOR/CHERYL: Sure, I'd love you if you were broke. But, you know what? I got paid today. I got us a room! Come on, come on, René. Let's go.

RENÉ: No, no. I'm not cool with that.

COUNSELOR/CHERYL: Come on, I got some for us to share, baby.

RENÉ: No, no. I'm not cool with that.

COUNSELOR/CHERYL: I got some *really* good #*%! here, René.

How To Follow Up Role-Play

In an individual session

1. Keep having the client do brief (2 minutes or less) role-plays to build confidence that he or she can do it.
2. If the client shows inability to follow through (e.g., the client gives in), one appropriate response would be, "Well, that didn't go so well, what do you need to do the next time to walk away?"

In a group session

When using role-play in a group, the clients are often much tougher than the counselor. When the client is successful in coping under these conditions, he or she has gone through both an emotional and a behavioral experience. Following the role-play:

1. Ask the person playing the client what he or she did well first; then ask, "How could you do it better?"
2. Ask the clients in the group what they thought went well and what could have been done better without repeating what someone else has observed.
3. Summarize the most important feedback: "Here's what the group said you could've done; let's do it again."
4. Repeat brief role-plays (about 2 minutes) until the client has a sense of mastery, and he or she is demonstrating an ability to handle the situation well.

Very short, repetitive role-plays work best. Each time clients role-play, they learn something more. When they feel they've learned all they can, their sense of mastery has improved and they feel they are prepared to handle the situation. If clients experience craving at the end of the role-play, use this as an opportunity to teach them to manage cravings.

RENÉ: I can't do that.

COUNSELOR/CHERYL: Come on, come on! Let's go, René.

RENÉ: No. I'm not cool with that. No. I've had it. I'm outta here! [*René gets up and walks away.*]

COUNSELOR/CHERYL: Come on, come on, René! You know we can feel good.

[René agrees to go to NA more often and has practiced coping skills in case he sees Cheryl. In the next session, it will be important to follow up on his use of these skills, explore how René manages his next encounter with Cheryl, and do more role-playing (if needed) to address any challenges that arise. He is ready to move into the boarding house and doesn't feel as vulnerable to relapse.]

Visit 3 (counselor's office)

René has decided he will stay in the halfway house until he is eligible to enter a sober living housing unit. He completed the outpatient program last week and had to vacate his program-provided apartment. The counselor begins Visit 3 with the following goals in mind:

- Review his attendance and commitment to daily NA meetings.
- Review relapse prevention coping skills.
- Review skills he needs to practice for long-term recovery.

The session begins with a review of how René is adjusting to the halfway house.

COUNSELOR: All right, well, the past couple times we met, we've been talking about how things have gone on payday, and we did the role-play about what you'd do if you ran into Cheryl.

RENÉ: Yeah, I really liked that. I saw her at a distance right before she saw me, so I got away.

COUNSELOR: There you go.

RENÉ: Yeah, I know, even though we went through that, you know, and I role-played, I really just want to keep myself from being in that position, so if I can see her first, I won't come in contact with her.

COUNSELOR: So, that'd bring up all kinds of feelings again.

RENÉ: Yeah, not that I don't know if I could deal with them or not, that's not the real issue. If I can keep from dealing with Cheryl in any form, I'm okay. But I know I'm eventually gonna run into her.

COUNSELOR: So, you've been going to your meetings?

RENÉ: Yeah. That sponsor of mine, he's crazy. He wants me to make a commitment, you know. I'm already working and #*%!, I can't do that. He wants me to be the coffee person at the meeting, you know, go buy the stuff, go do my 4th step, make the commitment.

COUNSELOR: So, what's your reluctance about making the commitment?

RENÉ: I don't have time. I don't wanna be the coffee person.

COUNSELOR: Okay. Well, at this time, you're going to need as many places as possible to be that are good places for you to be.

RENÉ: Yeah, that's what he said, too. Safety. Responsibility.

COUNSELOR: So, if it isn't being a coffee person, what else can you build in right now? What else are you doing besides the meetings and work and spending payday avoiding your girlfriend? How is halfway house living coming?

RENÉ: Well, it's okay. Some of the people I knew in the program are there. I like playin' chess, so I might start playin' chess again. There is one guy in the house who says he will play with me. I really do have time to be the coffee person, you know. I guess that's my own thing, not wanting the responsibility.

COUNSELOR: Sounds like maybe you want to do it. Maybe you're just talking yourself out of it.

RENÉ: Yeah.

COUNSELOR: It can be hard to make a commitment to another person.

RENÉ: Yeah, this guy wants me to do it. When I say, "Why do I have to be the coffee person?" he says, "Just be the coffee person." He needs to tell me what I'm gonna get out of it. I don't wanna just do it because he wants me to.

COUNSELOR: Well, you're always on time for appointments. You can keep an appointment. I'm wondering what it would do to how you think about yourself if you were responsible and dependable.

RENÉ: Well, I just don't think of myself that way. That ain't me.

Master Clinician Note: The counselor is helping René clarify how recovery-oriented relationships that include commitment and responsibility can be adaptive, healthy, and rewarding in contrast to his maladaptive relationship with Cheryl, his lack of responsibility in the past, and his reluctance to commit to anything.

RENÉ: I may be getting to the point where I don't need to go to meetings that often, you know?

COUNSELOR: So maybe you're trying to get away from committing yourself to the meetings.

RENÉ: Well, #*%!, I don't need to go 7 days a week.

COUNSELOR: Remember now, René, we're working on finishing your 60 days in the halfway house, then looking forward to moving into sober living. It's going to be here sooner than you know.

RENÉ: Yeah, yeah.

COUNSELOR: You're independent even in this, you know. And being in sober housing will be another step. In sober housing, there's nobody cooking, just a few other guys around, doing their thing, no staff. You'll be pretty independent.

Master Clinician Note: The counselor senses that René has begun a significant shift in his thinking about abstinence, relationships with others, personal attributes (e.g., responsibility, commitment), and his own personal sense of worth and dignity. He has found hope that he can reach for and achieve a quality life. These shifts accrue as a result of abstinence, stable living (such as stable housing and new "clean" friends), and quality treatment in the program. René still needs to incorporate these changes on a consistent basis but is making significant efforts in all these spheres. The counselor wants to support René's new view of himself in relation to the world and will continue to reinforce this growth in subsequent visits.

RENÉ: Yeah, but, I'm thinkin' he wants me to take the coffee commitment 'cause he thinks I'm gonna use if I don't take it. I'm saying I don't need to have a coffee commitment to keep me from using.

COUNSELOR: This is a big concern of yours right now. Someone else is relying on you.

RENÉ: Yeah, because now I can't miss. I know he thinks that it'll force me to have to go to the meetings. It gives me some responsibility, you know, so I'm gonna do it for a while. I can't say that I'm gonna be there for every meeting as coffee person, but I'm gonna try.

COUNSELOR: I think it's a good thing for you to do. You've been focused on yourself and your recovery, so now you're doing something for other people. It could be a good feeling, having people relying on you.

RENÉ: Well, maybe.

COUNSELOR: So, what else is going on?

RENÉ: Well, I need to make more money. The job—I need a new job. I'm gonna try to buy me a car, you know, and I wanna move into my own place.

COUNSELOR: Those are great goals, René. So, have you tried to get leads on something that might offer more pay?

RENÉ: That's the thing, you know. I don't know how to look for another job. The folks at the halfway house said they would help.

COUNSELOR: Well, how about if we go back to the halfway house director, maybe on your day off, and see what he might have? They have some stuff posted on the employment board.

RENÉ: Yeah, that's not a bad idea.

Master Clinician Note: The counselor is focusing on René's natural supports (NA meetings, his job, and maybe his family) to help him develop supports for his recovery.

COUNSELOR: Have you been in touch with your family at all?

RENÉ: Uh, no, not really. Been away from them a long time.

COUNSELOR: What do you think about making some contacts? Pretty soon, you'll have your own place. You can maybe have them over for coffee. Or are you thinking that would feel like too much pressure?

[They discuss reconnecting to René's family, particularly an uncle.]

COUNSELOR: Now, I'm just thinking about another person who might show their face while you're in sober living. Who do you think that might be?

RENÉ: Let's see, who could that be? [*laughs*] You're talking about Cheryl.

COUNSELOR: Yeah, I am. Have you thought about how that's going to work?

RENÉ: Well, first, she don't know where I'm staying. You know, I'd never give her my address. Haven't given her my phone number either. I don't go to that store anymore.

COUNSELOR: Have you been feeling lonely?

RENÉ: Yeah, you know, that's part of why my sponsor had me go to those meetings a lot. Doesn't give me a chance to be lonely. I'm still around a lot of people I can talk to.

COUNSELOR: You said you were not a real big people person, kind of a loner.

RENÉ: Yeah, but I'm in the room with them, so, it's all right. Yeah, I saw a girl there and we've been talking. She's in recovery, too, so it's all right.

COUNSELOR: Someone to think about for down the line.

RENÉ: Could be. Could be a prospect, yeah. But, you know, I really want to change jobs.

COUNSELOR: You changed the subject pretty quickly.

Master Clinician Note: The counselor understands René's abrupt shift to another topic as signaling his discomfort but decides to further explore the relational issue and help him begin to resolve it.

RENÉ: Yeah. I'm—

COUNSELOR: Maybe you need to think about how to deal with women who aren't using.

RENÉ: Well, my sponsor told me that I shouldn't be in a relationship anyway, you know?

COUNSELOR: This sponsor sounds like a very important person.

RENÉ: Yeah, well, he thinks he is. He has some good information—some good, some bad, some I don't agree with. But I have his number, and then if something happens, he tells me don't call him after I get high, you know. Call him before. Can't really do too much *after* I'm high.

COUNSELOR: So, it's been a while since you've been high. How's that going?

RENÉ: Going okay, you know? Got some good tools I use, you know. I do what they say; I play the tape all the way through, I see the consequences.

COUNSELOR: There's a lot going on. You moved, you're still adjusting, there's another move coming, you're staying clear of Cheryl, you're seeing other women, *and* you're keeping off drugs. That's a lot.

RENÉ: Yeah, it's tough!

COUNSELOR: You've stayed with the plan on payday, you haven't relapsed, you're making the best of being here, you're doing more meetings, and you're maybe thinking about making some contact with your family. That's all really good stuff.

RENÉ: Yeah, well, it's pretty good. I guess they say I'm well on my way, huh?

Master Clinician Note: The counselor continues to affirm René's strengths and what he has accomplished. This supports René's confidence in his ability to maintain his recovery and continue the evolution of his identity toward becoming a contributing member of his community and away from homelessness and substance abuse as a coping strategy.

Summary

René has come a long way. He slipped but worked with his counselor to stay in the action stage of change through the techniques used in transitioning from homelessness intensive care to ongoing rehabilitation (i.e., affirmation, identifying strengths and relapse triggers, role-playing, and increasing and generalizing coping skills). He moved from precontemplation to action for ending his relationship with his girlfriend and from contemplation to action about moving into a halfway house temporarily until he has enough time abstinent to enter a sober living home. He increased commitment to substance abuse recovery supports through involvement in NA.

Longer-term goals for working with René include:

- Ongoing engagement in mutual support groups and the recovery community.
- Reconnecting him with his family, including using role-play to practice asking his uncle to go fishing, having dinner with his aunt and uncle, and facing recriminations from his family.
- Finding a better job; using role-playing of job interviews until René has developed the skills he needs for telling the truth about his background.
- Assessing René's money management and living skills and improving them if necessary.

Vignette 6—Mikki

Overview

Mikki is in the early intervention stage of homelessness prevention. This vignette demonstrates approaches and techniques for preventing additional trauma to her family during temporary homelessness.

Mikki's partner of 4 years has abandoned the family, leaving Mikki with sole responsibility for their daughter, Emily, age 3, and for Madeline, age 7, Mikki's daughter from a previous relationship. For a couple of months, he sent some money, but for the past 2 months he has not been heard from. Mikki does not know where he is and does not expect him to return.

She presents in the local community health center with one child with a high fever and both children with bad colds and coughs. On interviewing Mikki, the nurse practitioner picks up on her significant depression and begins to question her about the family's living situation. She is concerned that Mikki's level of depression will not allow her to provide care for the children, particularly in emergency situations with their illnesses.

In the discussion, the nurse learns that Mikki has been evicted from their apartment and that the family has been living in her car (which is not working) for the past week. Mikki takes the older child, Madeline, to school each morning (except this morning, because Madeline is sick). She and the younger child, Emily, sit and play in the park all day. Mikki has no plans for coping with the crisis and, with her depression, can barely make it from day to day. She has been receiving some meals for her and the children at a local soup kitchen but has not told kitchen staff that she is homeless.

The practitioner is faced with three immediate problems:
1. Intervening with the children's health problems
2. Intervening with Mikki's serious depression
3. Helping the family find temporary emergency housing

The nurse contacts Bill, the behavioral health counselor/case manager at the community health center. The vignette depicts Bill's work with Mikki and the children.

Setting

Mikki and her two children present at a community health center. Bill, the caseworker, is called in after the nurse practitioner identifies the family as homeless and in need of acute care. Bill recognizes the complexity of this case, which, by his determination, calls for intensive case management and a team approach to care. He mobilizes resources within the health center and in the community to respond to the complex needs of this family.

Learning Objectives

- Recognize homelessness or incipient homelessness with individuals and families who present with other problems and do not identify homelessness as the presenting problem.
- Screen for and identify behavioral health problems and apply appropriate resources to address those problems.
- Mobilize and coordinate resources to provide interventions for complex, multiproblem families.
- Implement prevention strategies to limit the trauma of homelessness in families.

Strategies and Techniques

- Case management with families facing multiple problems
- Using SBIRT as a strategy for identifying substance abuse and substance use disorders
- Prevention strategies to engage children and parents in families experiencing homelessness
- Using a team approach in working with families with complex behavioral health issues

Counselor Skills and Attitudes

- Develop rapport with someone who is depressed and overwhelmed.

- Develop and implement a treatment/recovery plan for people in acute crisis who have co-occurring disorders.
- Develop case management skills in work with complex, multiproblem families.

Vignette

Visit 1 (health center)

The nurse practitioner has contacted Bill, a counselor who is currently seeing another client; Bill says he can see Mikki in about 45 minutes. It ends up being more than an hour before Bill is free, and Mikki becomes cranky. Emily, who waits with her mother, is restless and beginning to run up and down the hallway near the waiting room. Madeline is still in the pediatrician's office.

COUNSELOR: I'm sorry you have had to wait today. Things are pretty hectic around here this morning.

MIKKI: Will someone tell me when Madeline is through with her visit to the doctor?

COUNSELOR: Yeah, the nurse is going to call us. When she does, Madeline can join us here. I understand Madeline is feeling pretty bad today.

[Bill wants to initiate some connection with Mikki and involve her in a conversation but doesn't want to rush right into all of the overwhelming problems Mikki is facing. He engages Mikki in talking about the children's current health problems, and although Mikki continues to seem somewhat distant, she seems less cranky. Emily has put her head in her mother's lap and is beginning to doze off. As Bill senses Mikki feeling a little more comfortable, he asks a general question about her current situation.]

COUNSELOR: Mikki, it seems like you have a lot going on right now, some really tough stuff happening in your and your girls' lives.

MIKKI: I don't know how I'm going to handle all of this.

COUNSELOR: Well, we want to help you. Right now, Madeline is getting taken care of and Emily got a prescription from the doctor, so let's talk about your housing situation. I understand you don't have a place to live right now.

MIKKI: Not since last Tuesday.

Housing Options for Families in Crisis

In any particular community, a variety of housing options might be available for families in crisis. At the same time, no community is likely to have the full range of necessary housing services for families. Some organizations may have a complete range of "wrap-around" services available, such as assertive community treatment, emergency and comprehensive health services, family counseling, employment assistance, and a food pantry. Other organizations may simply provide housing. Some programs have restrictions on the length of time families may stay, whereas others provide permanent supportive housing. Some resources may be limited to mothers and their children, whereas others accept intact families. It is important for you and your program to be aware of the services available in your community, as well as to be aware of the gaps in available services.

COUNSELOR: Okay, Mikki. Let's take first things first. In addition to getting Madeline well, it seems most important right now that we help you get a place to stay for tonight that is safe and out of the weather.

[Bill proceeds to gather the information necessary from Mikki to arrange temporary housing. He also explains to Mikki that, for tonight (and maybe the next few days), he will arrange shelter housing; in the interim, they can plan for more stable housing. Bill also realizes that Mikki is depressed and overwhelmed. It might be a problem for her to go to the housing office for assessment on her own because her car is not working, but he has no immediate resources for taking her there. The office is about eight blocks from the health center. He therefore arranges for bus fare for Mikki and the girls.]

MIKKI: I don't have any money.

COUNSELOR: Mikki, I'm thinking if you can return here tomorrow, we'll start getting you some income support until you can get back on your feet and maybe start working.

MIKKI: That sounds okay.

[Madeline now enters the room accompanied by a nursing assistant from the pediatrics department. She is a shy, thin child who does not make any eye contact with Bill. When the nursing assistant leaves the office, Madeline sits quietly next to her mother. Emily begins to stir, but Mikki doesn't seem to respond to Emily's waking up.]

COUNSELOR: Well, Mikki, if the kids are ready, maybe you should head over to the shelter

Family Shelters and the Need for Permanent Housing

Shelter services provide emergency housing services to families without a place to live. Often, these services are limited to mothers and children who require immediate housing resources and are time limited in nature. A variety of dynamics drive families to shelters and other transitional housing resources: the lack of local low-cost housing, the disparity between housing costs and income, domestic violence, and limited availability of other social service resources, among others. Some of the barriers faced by families who are homeless are available cash for a rental damage deposit and first and last months' rent, limited housing stock for larger families, and the reluctance of landlords to rent to individuals who have been previously evicted from housing or who have a poor credit history. These dynamics create a cycle of emergency homelessness crises for families in need.

Shelters and other transitional housing meet a significant need in most communities. However, shelters are often just the first step needed by a family without housing. Most housing experts cite the need for intensive long-term housing assistance for families to stabilize and grow beyond the immediate crises that caused their homelessness in the first place. Supportive social services for employment, behavioral health services, physical health care, education, clothing, and food are required over a longer period of time than can be provided by most transitional services.

Housing First is an option for emergency shelter/transitional housing. As the name implies, this program sees adequate and sustained housing as a precursor to support families as they get back on their feet. In addition, Housing First services provide social services to support families. The four stages of most Housing First programs are: crisis intervention and short-term stabilization, screening and needs assessment, provision of housing services, and provision of case management services.

Source: National Alliance to End Homelessness, 2006.

offices to arrange for housing for tonight. Then tomorrow, be back over here at 9, and let's see what we can do to start working on things like income and more stable housing.

[Mikki bundles up the girls, takes the bus fare and a map to the shelter office, and leaves the health center with a return appointment for the next morning.]

After Mikki leaves, Bill spends a few minutes developing some ideas for addressing Mikki's needs. Some of the actions he identifies, in order of priority, are:

1. Find housing for the next couple of days, and, in the interim, arrange for more stable housing.
2. Arrange for the family to receive intensive case management and social work services from the health center that will allow Bill and other support personnel in the center to provide more concentrated and intensive services.
3. Address Mikki's depressive symptoms.
4. Find an income source that can support Mikki and her daughters until she can gain employment.
5. Monitor the needs of the children; in particular, monitor Madeline for school attendance and potential depression, ensure that the health and safety needs of both girls are met, and arrange interventions to mitigate any trauma they may experience due to their life situation.
6. Help Mikki access resources she needs to apply for a job that can help her support herself and her children.

Visit 2 (counselor's office)

Mikki returns to the health center the next morning at 9 to see Bill. She is accompanied by her 3-year-old, Emily. Madeline went to school this morning. Mikki looks disheveled, despondent, and overwhelmed and doesn't seem to be responding to Emily's efforts to stay close to her. After yesterday's visit, Bill requested and got approval for increased intensity of casework services. This allows Bill and a case aide to see Mikki on a more regular basis and to accompany her to appointments that are critical to the family's welfare.

Bill invites Mikki and Emily into his office.

COUNSELOR: I hope you got to the housing office okay yesterday. How's it going?

MIKKI: We got to the housing office yesterday after it closed, and the shelter wouldn't let us in without a voucher, so we slept in the car again last night.

COUNSELOR: Did you and the girls get any breakfast?

MIKKI: We had some supper at the open kitchen down the street from the housing office. I don't have any money for breakfast.

COUNSELOR: Okay, then as soon as we finish here, I'll arrange a food voucher for you and Emily to get something to eat. Would it be okay with you if I call Madeline's school and see if we can arrange for her to get breakfast and lunch there each day she attends?

[Mikki nods her assent to both statements, and Bill proceeds to complete a release of information form with her, which will allow him to communicate with the school counselor. Mikki signs the form without really reading it. Bill notices this and proceeds to explain what the form means.]

Effects of Homelessness on Children

Children in families that are homeless are affected at all psychodevelopmental levels, from before birth to late adolescence. These effects influence physical growth, emotional and behavioral development, academic performance, and interpersonal and social skills development (Shegos, 1999).

Additionally, homelessness for children, as well as for adults, rarely exists in isolation; rather, it occurs most often in the context of other dynamics such as the potential for violence, poverty, living with recurring crises, inadequate nutrition, and family breakup. As a result, children in families that are homeless are at particular risk for trauma and developmental and behavioral disorders. For more information on trauma-informed care for children and families who are homeless, see SAMHSA's National Center for Trauma-Informed Care Web site (http://www.samhsa.gov/nctic/) and SAMHSA's Homelessness Resource Center Web site (http://homeless.samhsa.gov/).

COUNSELOR: Mikki, I sense that you are pretty down in the dumps this morning.

MIKKI: Have you ever tried to live in a car with two daughters and one sleeping bag? I don't have any money. I'm tired. I don't know where we will sleep tonight. I haven't had a bath in 3 days.

[Mikki begins to tear up. Bill just sits silently for a few moments without interrupting her.]

COUNSELOR: I understand that things are really overwhelming for you right now. It must feel very difficult for you to get anything done. But I'm here to help you, and together, we can begin to take these big problems and deal with them one by one. Now first, I'm going to arrange for Kate, our case aide, to go with you this morning after you've had breakfast to enroll you and the girls in the family shelter housing program for a few days until we can get something better worked out. It's safe, and you'll have a place for your stuff, a bathroom, and a small breakfast meal to get you all going in the morning.

Once we have that squared away, Kate is going to walk over with you and Emily to the Department of Human Services to help you get enrolled in some emergency financial assistance. It won't be a lot of money, but it will help you get through the next few weeks. Are these plans okay with you?

MIKKI: Well, I don't have anything else to do, that's for sure. I do have to meet Madeline at the school at 3. She gets real nervous if she thinks I'm not going to be there.

COUNSELOR: No problem, we should be able to get the housing and income assistance stuff tucked away well before 3. Now, Mikki, there is one more thing I would like us to do this morning, and then we can arrange for you and Emily to get some breakfast—and that is, I would like you to see a doctor on our staff, Dr. Wright. I know you are really overwhelmed and pretty down right now, and that is really sapping your strength. We're taking care of the girls' health, but your health is important, too. So, I want you to see Dr. Wright, who is our staff psychiatrist. Let's see what we can do to help you get more energy, get some good sleep, and feel more hopeful about things.

[For more information about depressive symptoms and their treatment, see TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (CSAT, 2008).]

MIKKI: You want me to see a psychiatrist?

COUNSELOR: I'm concerned that you may be depressed, and, like any illness, depression is likely to get worse if it isn't treated. We have a lot of resources here at the health center that can help you, and Dr. Wright is one of them.

[Mikki reluctantly assents. Bill takes a moment in the presence of Mikki to call Dr. Wright's secretary and arrange for an assessment interview later in the week. He then writes down the appointment time for Mikki and arranges for her to come by his office for a few minutes before she is scheduled to see Dr. Wright. He then arranges for Mikki to receive two meal vouchers from the health clinic and schedules Mikki to meet Kate, the case aide, in 1 hour. While Mikki is having breakfast, he updates Kate on the case. Kate will be able to check in with Mikki regularly just to make sure everything is going all right. He then calls Madeline's school and speaks with the school counselor, who suggests that, in addition to enrolling Madeline in the breakfast and lunch programs, she can meet briefly with Mikki this afternoon when she comes to pick up Madeline and see what support she can offer Mikki and Madeline.

Bill prepares his case notes and a referral request to Dr. Wright, describing his concerns about Mikki's depressive symptoms and the efforts that have been taken to support Mikki and her daughters.]

Later in the week

Mikki, with Kate's help, got housing through the family shelter, arranged for Madeline to remain in the school meals program, got emergency financial assistance, and kept her appointments with Bill and Dr. Wright. Dr. Wright suspected that alcohol use might be contributing to Mikki's depression and conducted an SBIRT assessment.

The screening indicated that Mikki was using alcohol in a manner consistent with substance abuse, particularly in the past month. The brief intervention consisted of a discussion with Mikki about her alcohol use, helping her understand the ways in which alcohol might heighten her depression and interfere with her recovery. This elicited her cooperation in remaining abstinent

Screening, Brief Intervention, and Referral to Treatment

As described on SAMHSA's SBIRT Web page (http://www.samhsa.gov/prevention/sbirt), SBIRT is a comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur:

- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

Please refer to the SBIRT Web page listed above as well as the text box on page 36 of this TIP for more information on SBIRT.

while in treatment for depression and her participation in continuing follow-up with Bill. She was encouraged to attend a weekly support group that meets at the family shelter. Bill will follow up with Mikki on her efforts toward abstinence and monitor her mood. She has a return appointment in a month to see Dr. Wright. Additionally, Dr. Wright prescribed an antidepressant medication for Mikki.

Visit 3 (one month later, counselor's office)

Kate, with Bill's support and supervision, has continued to check in on Mikki twice a week. Mikki's depressive symptoms are less intense, and she seems to be doing a better job of supporting her children. After spending four nights in the emergency family shelter, Mikki and the girls moved to transitional family housing, where they continue to live.

Bill has maintained contact with Annette, the counselor at Madeline's school, who has helped Bill understand some of the effects of homelessness on young children and some of the programs and resources that are available for children to prevent additional, compounding problems. Through Kate, Bill has made time to see Mikki to check in with her before her appointment with Dr. Wright.

MIKKI: Hi. Kate said you wanted to see me.

COUNSELOR: Hi, Mikki. It's good to see you again. Things were pretty tough for you the last time we were together. Kate has been keeping me updated; it seems things are going a lot better.

MIKKI: Yes, they are. I need to get a job and a better place to live, but the girls are doing better.

COUNSELOR: And you? How are you doing?

Transitional and Permanent Supportive Housing

Two primary approaches to housing services include transitional supportive housing and permanent supportive housing. Transitional services are designed for people needing more than emergency housing assistance, but with an expectation that within a period of approximately 2 years, they will be able to move away from supported housing using their own resources. Many people are able to move from transitional housing sooner. Some examples of clients who often need transitional housing are families whose major breadwinner has lost a job and been unable to find other employment, people who are homeless when leaving substance abuse treatment, and families affected by domestic violence. Typically, transitional housing is accompanied by social, health, behavioral health, and other services to support the individual or family in rehabilitation from homelessness.

Permanent supportive housing is more likely to be an appropriate choice for individuals who face long-term rehabilitation from homelessness and have co-occurring behavioral health or physical disabilities. Permanent supportive housing needs to be accompanied by a variety of social, health, behavioral health, financial, occupational, and interpersonal services to enable the individual to function optimally in the face of difficulties.

In both transitional and permanent supportive housing, the type of appropriate housing depends on a variety of contexts, including housing availability in the community, the specific needs of the individual or family, cost, and the availability of adjunct services. The housing may range from SRO units to conventional apartments in the community.

Source: HUD, 2008.

MIKKI: Well, better. I'm sleeping at night, even though the Family Living Center is loud and our room faces the street with traffic all night. I've got to find a better place to live, but that takes money. I'm also just sitting around all day. There isn't much to do. They don't like you downstairs watching TV all day.

COUNSELOR: What about drinking?

MIKKI: No drinking. When I saw the doctor, he told me I should quit, and the support group has helped a lot, too. I really couldn't afford it anyway. Mostly, I drank at night to sleep better, but I think I'm sleeping better now without drinking. My boyfriend drank every day, and I got to drinking with him. Now I'm through with him and the drinking.

Master Clinician Note: The counselor decides to monitor Mikki's progress with not drinking as he continues to maintain contact with her; he also wants her to have options for help if she does begin drinking again.

COUNSELOR: What do you think would be helpful for you if you did find yourself drinking again?

MIKKI: Well, I don't think that is going to happen, but I guess I would just stop.

COUNSELOR: And if you find that despite your intentions, you can't stop?

MIKKI: Well, could I give you a call?

COUNSELOR: Sure, I plan to be around a while. But also, if you aren't able to reach me, for instance, maybe you've moved away, would you be willing to contact some resource in the community that could help you—for instance, a local alcoholism clinic or AA?

MIKKI: Well, I really don't intend to start, but sure—if I see that I'm drinking again, I can do that.

Master Clinician Note: The counselor knows that Mikki would benefit from discussing how she would know when to seek help. He can also provide additional contact information that might come in handy in the future. He also wants to encourage Mikki to attend some AA meetings but decides to wait on that suggestion because of the multiple issues she still needs to address.

COUNSELOR: Have you heard from your boyfriend?

MIKKI: No, not a word. I don't know if he would even be able to find me now. I'm not wanting to find him right now, either. Maybe he was more of a problem than a solution.

COUNSELOR: Well, Mikki, I'm really happy to see you doing so much better. We have a few minutes before your appointment with Dr. Wright, so I'd like to talk with you about the girls. I know you've seen Annette, Madeline's school counselor, at least once since we last met. I talked with her last week. She would like to see Madeline get into some support programs if that's okay.

MIKKI: What kind of programs are you talking about?

COUNSELOR: Well, one is an after-school program that runs until 6 each school day. It would help Madeline have a place where she could be with other kids after school. She would get a snack, have a chance to rest, and get her homework done. Annette says she also thinks she can get Emily into an afternoon preschool program that goes from 1 to 6 in the same building where Madeline would be. That would give you some time to yourself to begin getting things together in your life.

MIKKI: I could use some time to look for a job. What do I need to do about seeing this lady to get help for Madeline and Emily?

COUNSELOR: While you're seeing Dr. Wright, I'll see if I can reach Annette. Maybe we can arrange a time for you to go by her office at the school. Why don't you check with the receptionist's desk after seeing Dr. Wright? If I'm with someone else, I'll leave you a note there. If not, the receptionist will let me know you are available.

[Mikki proceeds to Dr. Wright's waiting room. Bill calls Annette's office, and they arrange an appointment time for Mikki to visit with Annette tomorrow.]

The next day

Mikki arrives at Madeline's school about an hour before school is let out, and she meets with Annette. Annette does arrange after-school services for Madeline and also enrolls Emily in afternoon preschool services. Annette also arranges for two other important services for Madeline: a support group similar to the Curriculum-Based Support Group Program she has read about and a summer program based on Coping Cat, which she saw on the Internet.

Five months later

Mikki drops by Bill's office while she is at the health center with Emily, who is getting immunizations. Mikki started out seeing Bill once a week for a couple of months, and then they decreased their visits to every other week. When she got a job, it became difficult to schedule appointments with Bill, so she began checking in via telephone. She is now working 6 hours a day as a housekeeper in a local upscale hotel. Emily is in child care while she works. The family

Evidence-Based Prevention Practices for Children

SAMHSA's NREPP is an annotated list of programs for which there is empirical evidence of effectiveness (see http://nrepp.samhsa.gov/). Among those are the two to which Madeline has been referred.

The **Curriculum-Based Support Group Program** is based on cognitive–behavioral and competence-enhancement models. It is designed to teach life skills and offer emotional support to help children like Madeline cope with difficult family situations; resist peer pressure; set and achieve goals; refuse alcohol, tobacco, and drugs; and reduce antisocial attitudes and rebellious behavior. The school has prepared a workbook for parents of children in the group and will host a late afternoon parents' session with supervised games and activities for the children.

The school's **Coping Cat** program combines summer camp activities with cognitive–behavioral treatment that assists school-age children in (1) recognizing anxious feelings and physical reactions to anxiety; (2) clarifying cognition in anxiety-provoking situations (e.g., unrealistic expectations); (3) developing a plan to help cope with the situation (i.e., determining what coping actions might be effective); and (4) evaluating performance and administering self-reinforcement as appropriate.

Coping With Work and Family Stress

This workplace preventive intervention is designed to teach employees 18 years and older how to deal with stressors at work and at home. The sixteen 90-minute sessions, typically provided weekly to groups of 15–20 employees, teach effective methods for reducing risk factors (stressors and avoidance coping) and enhancing protective factors (active coping and social support) through behavior modification (e.g., methods to modify or eliminate sources of stress), information sharing (e.g., didactic presentations, group discussions), and skill development (e.g., learning effective communication and problem-solving skills, expanding the use of social networks). The curriculum emphasizes the role of stress, coping, and social support in relation to substance use and psychological symptoms. Usually, a facilitator with a master's degree who is experienced in group dynamics, systems theory, and cognitive and behavior interventions leads the sessions. For more information, visit the NREPP Web site (http://nrepp.samhsa.gov).

last week moved into supported housing, a program for formerly homeless families. Mikki has continued to see the psychiatrist and a social worker at the health center regularly and is much improved. She continues to maintain abstinence and is able to help Madeline with her homework; last weekend, the three of them went to a local community fair and had a great time. This weekend, they are shopping at local used furniture outlets for furniture for their new apartment. Mikki is taking advantage of a program offered by her employer (see text box above) to help prevent her stress from becoming a barrier to her keeping her housing and maintaining abstinence.

Long-range plans for Mikki and her children are:

- For Mikki to continue receiving treatment and support services at the local health center:
  - To stabilize in remission from her depressive episode.
  - To learn more about how to manage her recovery from her depression and alcohol use and to act early if she perceives a relapse coming.
  - To continue to develop better coping and parenting skills.
- To stay on the list for Section 8 housing and to move when this becomes available.
- For Mikki to continue to make plans with her parents to possibly return to her hometown (in the same county) to live with her daughters. These plans would include contingencies for:
  - Local supported housing.
  - Continuing mental health services.
  - Signs of trauma reactions in the children related to what they have experienced in the past year.
  - Making plans to obtain long-term employment.
  - Maintaining abstinence from alcohol.

Vignette 7—Sammy

Overview

Sammy is in the permanent supportive stage of homelessness rehabilitation. The vignette shows approaches and techniques for arranging PATH-supported services and housing for a client who has SMI.

Sammy, a 34-year-old man, was discharged from the State hospital last week and referred to a community mental health center (CMHC) for continuing care; he has yet to contact them. He

spent his first night after discharge with his parents but argued with them the next morning and left. He then spent several nights with a friend with whom he stayed occasionally before his hospital admission. Last night, he had a few beers and was arrested for public intoxication, creating a disturbance, and panhandling. He spent the night in jail and this morning, as an alternative to incarceration, agreed to meet with the street outreach program staff. Street outreach in this community is a joint venture of a coalition of homelessness programs and the local CMHC. After the initial interview in jail with a mental health PATH caseworker, it was decided that Sammy would go with the caseworker to Welcome Home, a transitional housing program, and apply for long-term supported housing. The PATH caseworker will follow Sammy's progress and help him transition to the community while maintaining housing at Welcome Home.

Learning Objectives

- Use community housing and behavioral health resources to help an individual live in the community and avoid rehospitalization.
- Help clients learn about and access permanent supportive housing with support from the PATH staff.
- Provide client-directed, recovery-oriented services for housing.
- Integrate community mental health services (e.g., ACT) into a client's recovery program.

Strategies and Techniques

- Engage the client in community services to support recovery and get permanent supportive housing.
- Support the client in making housing decisions.
- Use community recovery resources (e.g., National Alliance on Mental Illness [NAMI]) to create ongoing recovery support.

Counselor Skills and Attitudes

- Develop rapport with a client who does not easily engage with others.
- Manage client resistance to accepting permanent supportive housing.
- Assess client strengths and limitations in developing a housing plan.
- Understand community resources for housing for clients with SMI.

Vignette

Visit 1 (Welcome Home offices)

Mike, a mental health caseworker, spent a few minutes developing rapport with Sammy, gathering some history and assessing his current life situation. This information revealed that Sammy has not had a permanent residence for nearly 4 years. He has lived primarily at a deer hunting camp in the forest about 20 miles from his hometown. He maintains the camp for the hunters who own it in return for a room of his own there. When he comes to town by bus or hitchhiking, he may spend a night or two with his friend. He has had three admissions in the past 8 years to the State psychiatric hospital, all related to going off antipsychotic medications and using alcohol. Between hospitalizations, he has intermittently received care at the local CMHC. He doesn't like taking medication due to side effects but recognizes that he needs to take it to stay out of the hospital.

What Is PATH?

Projects for Assistance in Transition from Homelessness is a SAMHSA-administered formula grant program that funds community-based outreach, mental health, substance abuse, case management, and other support services for individuals who are homeless or at risk of becoming homeless and have a serious mental illness or co-occurring disorders. The program was authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. Monies are distributed by SAMHSA's Center for Mental Health Services to States, the District of Columbia, Puerto Rico, and the U.S. Territories. States then distribute the monies to local programs to meet defined local needs. In this sense, each local PATH-funded program is different, reflecting the unique needs of the community it serves. For more information, visit the PATH Web site (http://pathprogram.samhsa.gov/).

PATH providers work with service delivery systems and embrace practices that work by:

- Partnering with Housing First and permanent supportive housing programs.
- Providing flexible, consumer-directed, recovery-oriented services to meet consumers where they are in their recovery.
- Improving access to benefits, especially through Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), Outreach, Advocacy, and Recovery (SOAR).
- Employing consumers or supporting consumer-run programs.
- Partnering with medical providers, including Health Care for the Homeless and community health centers, to integrate mental health and medical services.
- Improving access to employment.
- Using technology, such as hand-held devices, electronic records, and Homeless Management Information Systems.
- Training local provider staff on strategies to help people with serious mental illness who are homeless.

Local PATH-supported organizations provide homelessness support services, including:

- Outreach.
- Screening and diagnosis.
- Habilitation and rehabilitation.
- Comprehensive community-based mental health treatment.
- Alcohol and drug treatment.
- Case management.
- Supervision in residential settings.
- Services to help clients access appropriate housing.

About 6 years ago, Sammy lived briefly in a group home, was involved in a local drop-in day program supported by NAMI, and was able to work part time at a local carwash. Sammy says he prefers to live alone; living in the group home was "too close" for him. He felt too many pressures, and the staff's expectations were too high.

The vignette starts with Sammy and Mike (the counselor) as they consider alternatives for housing.

COUNSELOR: Sammy, let me see if I'm understanding you correctly. First, you need a place to live, at least for a while, because the guys at the deer camp say you need to prove you can do okay and stay out of trouble before you go back out there to live. Second, going home to your parents doesn't seem like a very good idea. Third, you need a place that you can call your own, without sharing a room, and lastly, you need a place you can afford. Am I correct about all of this?

SAMMY: Pretty much. I don't want to go back to my parents' house or a group home. Been there.

COUNSELOR: Okay. Here's the way I see things. Let me know what you think. Number one is that we need a place for you to just hang your hat for a while until we can find a longer-term solution.

SAMMY: [*interrupting*] What do you mean, "hang my hat for a while"?

COUNSELOR: Just a place for you to stay, maybe a week, maybe longer, until we can help you find a place, arrange for financial support, get you hooked up with the ACT team at the mental health center. That sort of thing.

SAMMY: I could just live with my friend until you find me a place.

COUNSELOR: Remember that the judge this morning made finding adequate housing, getting involved with the mental health center, and getting settled in conditions for staying out of jail.

SAMMY: I don't want to go back to that jail. Place smells. And it's noisy.

COUNSELOR: Okay, Sammy, here's what I'm thinking. I know I can get you a room, at least for a week, at the local shelter. I was over there yesterday, and they have some room. Would you be willing to go over with me and take a look?

SAMMY: Uh-huh. I guess so.

COUNSELOR: Okay, just in summing up, let's see what we need to do from here. We're going to take care of your housing for the next few days by going over to the shelter office. But also, if it is okay with you, I want to call Jeanette, who is on the ACT team at the community mental health center; let's get your appointment arranged. You've been through a tough 24 hours, and I want to be sure you have some support so you can minimize things turning tough again. And then we have to get you some money so you can buy a few things like a razor, and maybe a duffle to keep your meds and stuff.

SAMMY: I've got some money; my parents gave me $100, and I still had about $35 when I left the jail this morning.

COUNSELOR: Great! Maybe that'll last you for 2 or 3 days. The shelter will take care of your food. Now, I need your permission on a release of information form to call Jeanette. Is that okay?

SAMMY: Uh-huh.

[Mike proceeds to complete the release of information form and explains it to Sammy, who then signs in the presence of the housing office secretary and Mike. Mike then calls the shelter office to be sure someone will be available to meet with Sammy and him in about an hour. He then calls Jeanette at CMHC in Sammy's presence, but she is unavailable and will return the call that afternoon.

Mike and Sammy then proceed to the shelter office, where they arrange housing in an SRO setting for the next week. Back at the office, Mike gets the call from Jeanette and makes an appointment with Sammy for the ACT team tomorrow morning. He calls the shelter office, which passes the information about the appointment on to Sammy. Mike will accompany Sammy to his first visit at CMHC.]

Visit 2 (meeting with the ACT team)

Before meeting with the ACT team, Sammy and Mike spend a few minutes in the park across from CMHC. Sammy says that his room at the shelter is "better than the jail, but not much." He is very interested in getting his own apartment as soon as possible. Mike agrees that they will meet tomorrow and begin working on finding an apartment through the PATH-supported services program. Mike is also concerned that Sammy needs a range of services to meet a variety of needs: housing, mental health treatment, something to do during the day, developing interpersonal supports in the community, gaining income, achieving family reconciliation, ensuring proper nutrition, obtaining transportation, and so on.

No one program in the community can address all of these needs, and Mike will be the initial linchpin in coordinating these services. Mike begins to prioritize mentally how he will approach this task of coordination. As the ACT team engages Sammy, most responsibility for his care will be handed off to the ACT team; Mike will begin to withdraw from active participation in Sammy's treatment.

When it is time for Sammy's visit with the ACT team, Mike accompanies him across the street. Sammy first meets with Jeanette, an ACT team social worker, who completes the intake interview. Sammy and Mike then meet with the entire ACT team, and they jointly come up with a short-term treatment plan that includes:

- Regular prescription medication and compliance monitoring by the ACT team with Mike's support.
- Daily contact with the ACT team Monday through Friday for the first month, with a plan to

What Is an ACT Team?

ACT is an evidence-based practice (see http://nrepp.samhsa.gov/) developed in the late 1960s. ACT (sometimes known as PACT) teams provide intensive, individualized care, including direct treatment, rehabilitation services, and support services to persons with chronic and persistent mental illness 7 days per week (sometimes 24 hours a day). ACT care is distinguished from traditional community mental health services in that ACT team members work collaboratively to provide most services. The client is a client of the team, not of an individual service provider. In traditional mental health treatment, services are provided by a variety of different practitioners in a variety of settings, leading to fragmented and sometimes contradictory care. Team members in ACT include psychiatrists, psychologists, social workers, licensed mental health counselors, nurses, rehabilitation counselors, and recently, peer counselors.

Some principles of ACT, as identified by the Assertive Community Treatment Association, include:

- The ACT team is the primary provider of services.
- Services are provided in the client's environment, as well as in the ACT office.
- Services are highly individualized.
- ACT teams act assertively to encourage clients to participate in recovery.
- Services are provided over a long term.
- There is an emphasis on vocational services.
- The team provides substance abuse services and psychoeducation.
- Family support services are provided.
- Clients are supported in engaging and integrating into the community.
- Healthcare needs are addressed through education, evaluation, referral, and follow-up.

What Is NAMI?

NAMI is a nationwide voluntary organization with 1,200 affiliates throughout the United States that advocates for better understanding and resources for people with mental illnesses. It provides a variety of services and resources, including the NAMI Center for Excellence. Some basic services that might be provided in a community program supported by NAMI or another organization could include psychosocial skill training, mental health rehabilitation, case management, designated payee services, and drop-in services for clients and, possibly, their families.

taper contact to three times weekly in the second month, then once weekly after 3 months.
- Daily attendance at a local NAMI-supported recovery group at CMHC for 3 months.
- Weekly attendance at a contemplation/preparation/action co-occurring disorders group at CMHC.
- Collaboration between Mike and Sammy in a transitional manner until Sammy is in permanent housing, then transfer of all services to the ACT team.
- Contact information for 24/7 access to the ACT team in case of any psychiatric emergencies.

[Sammy, Mike, and the ACT team agree to the terms of the treatment plan, and all participants sign it. Sammy will begin the NAMI support group tomorrow morning and will check in with the ACT team during his morning NAMI meeting. Mike makes an appointment with Sammy to meet the following afternoon to begin the application for a supported housing apartment.]

Visit 3 (counselor's office)

Mike and Sammy meet to begin the application process for Sammy to obtain an apartment through the supported housing program.

SAMMY: I don't like this shelter thing. People are everywhere, and they all talk too much. It's just like the group housing thing I was in back a few years ago!

COUNSELOR: You seem to be getting uncomfortable with all the people. How are you handling that?

SAMMY: Well, they make you leave the place by 9 in the morning, so I go over to the NAMI program. And then they won't let you back in until 4:30, so after NAMI is over, I just hang in the park. Don't know what I'll do if the weather gets bad. Then once I get back in the shelter, I just go to my room. But I can still hear them through the walls. My room is right over the community room. They've got that TV blaring, and then the people have to talk even louder. I don't like it. It's too loud. At the deer camp, I could go 3 days without hearing anything but the crickets.

COUNSELOR: Sammy, I really understand that, and I know that it's making you uncomfortable. But I'm wondering if you can just hang in there until we can work out something better. Maybe have your own place in a week or 10 days. Could you do it?

SAMMY: Well, do I have a choice?

COUNSELOR: I don't know. What do you think? I hear that this makes you uncomfortable; remember that you and I, working together, are going to try to get you a better place as soon as we can. You're going to have lots of say in the place you get, where it is, how it looks. You'll even meet with the landlord before we close the deal. Meanwhile, you need to decide if you can hold

out until this lands, which it will. Let me ask you: In the past, when things have been noisy, what's worked best for you to deal with it?

SAMMY: Well, I've had some beer. But I know I can't do that right now. Sometimes I put on headphones and listen to music. That helps sometimes.

COUNSELOR: That sounds like a great idea to experiment with again.

SAMMY: Okay.

COUNSELOR: Let's get some details about your housing needs, how you'll pay, and your preferences.

[Mike and Sammy continue to discuss the details of Sammy's housing needs. Sammy has concerns about the neighbors, his privacy, rules that might be imposed on him, and who can access his apartment. Mike is concerned about public transportation availability, a cooperative landlord, finding an apartment in the rental range Sammy can afford, and the quality of the apartment. Mike encourages Sammy to apply for SSDI support, and his lead clinician on the ACT team will participate in arranging for him to have an appointment to begin the process at the local Social Security office. A local NAMI recovery coach will also assist him in the process. This process can take 6 months to a year, and, in the interim, the local homelessness coalition will pick up the costs of Sammy's rent. After (if) he is approved for SSDI, then 30 percent of his check will be applied toward the cost of the apartment. Likewise, if he doesn't receive SSDI, but finds another source of income, a portion of that income will go toward his rent.]

Master Clinician Note: The kinds of information Mike might want to collect to help Sammy find a suitable apartment could include the following:

1. What area of town does Sammy want (or not want) to live in?
2. Is Sammy aware of any apartments that he thinks would be suitable?
3. What about bus routes or other available transportation in the area?
4. Are there grocery and other stores in the area that Sammy can use?
5. Are there laundry facilities in the apartment itself, in the apartment building, or nearby?
6. Can Sammy easily access his mental health service provider for appointments?
7. Are utilities included in the rent? If not, are there utility deposits, and who will pay the deposits?

Visit 4 (in the community)

The next day, Sammy and Mike go apartment hunting among the apartments approved by the local affordable housing program. They look at several furnished units, each having some disadvantages for Sammy's particular situation. The fifth apartment visited seems to meet Sammy's needs and seems to Mike like a good match. It is an upstairs one-bedroom unit in a building with seven other apartments, about six blocks from CMHC, and it's near a grocery store. The unit has a small, parklike lawn in front, is on a bus route, and seems secure. The basement includes a washing machine and a clothes dryer. It has minimal but acceptable furnishings. Sammy was initially concerned that there was no TV but then said he thought his parents would let him have the old TV from his room at their home. The rent is $400 a month, which is within the

range of affordability for the housing program. There are two other units rented to participants in the PATH housing supports program.

> **Master Clinician Note:** The counselor needs to know how housing is approved or preapproved for supportive housing programs. All supportive housing programs investigate potential housing units prior to their eligibility in the program. Most programs have Housing Quality Standards criteria that must be met. The program is also likely to want statements from the owners of the available units that they are willing to work with the housing program. Before signing a lease, renters need to have a clear understanding of a variety of issues: for instance, whether the lease will be in the name of the program or the client, whether there is a deposit and how much it is, whether utilities are included in the rent, whether smoking is allowed in the apartment, arrangements for pest control, and whether there are rules about visitors. Many programs must complete a HUD-required Rent Reasonableness Survey to ensure that the rent is in line with community standards.

Sammy and Mike meet with the apartment manager, who lives in an apartment on the second floor adjacent to the unit Sammy will rent. He mentions that he would like to help Sammy and that he himself was a patient at the State psychiatric hospital several years ago and, after obtaining housing in the building, had become the manager about 3 years ago. Sammy, although a bit distant, seems to like him. The manager is interested in how Sammy will spend his day, goes over the basic rules of the apartment building, and offers to help Sammy get settled in.

After the meeting with the apartment manager, Sammy and Mike sit for a few minutes on a bench in front of the apartment unit.

SAMMY: So, when can I move in?

COUNSELOR: Well, here are some things we need to do first: [*Sammy sits quietly.*] First, do you think it would be a good idea to let your parents know what's up?

SAMMY: Yeah, I can give them a call. They were paying my cell phone bill while I was in the hospital, and I have it back, so I can call them.

COUNSELOR: Maybe they would like to see the place.

SAMMY: Nah. They don't need to see it.

COUNSELOR: Okay, well, what else do you need to do to get moved in once we have everything arranged on our end?

SAMMY: I don't know. Move the little stuff I have, I guess. I'll get Mom to give me some dishes and kitchen stuff. I can cook and they'll give me a little money to buy some food—pasta and that kind of thing. I don't eat much. This medicine makes me fat if I eat too much.

COUNSELOR: What about sheets, toilet paper, that sort of thing?

SAMMY: Well, I know I can't keep my mom from coming over here, once she knows where I'm living, and she'll bring that stuff.

COUNSELOR: Okay, now, you'll be going to the NAMI Recovery Program every day, and, for now at least, you'll be checking in with the ACT team. Every week, you get your meds from them. I think you are all set, Sammy.

Visit 5 (NAMI Recovery Program facility)

Ten days later, Mike checks in with Sammy while he is attending the NAMI Recovery Program. Sammy has moved into his new apartment and watched a football game with Frank, his apartment manager, last evening. He has made some acquaintances with other participants in the NAMI Recovery Program. Sammy and Mike find a quiet corner to visit for a few minutes.

SAMMY: I'm going to go out to the deer camp for a few days next week.

COUNSELOR: What about your participation in this recovery program and your ACT team visits?

SAMMY: What about 'em?

COUNSELOR: Well, my understanding of our agreement is that you are supposed to participate in these programs every day.

[Sammy doesn't answer, and there is a long pause.]

COUNSELOR: So, Sammy, let's see. If I understand you correctly, you want to go visit the deer camp, and we need to find a way for that to happen that doesn't interfere with your ACT team involvement and your participation in the NAMI Recovery Program. How do you envision doing that?

SAMMY: I'm just going for a few days—to check on things.

COUNSELOR: And you would be going by yourself?

SAMMY: Yeah, I'll take a bus out. They let me out at the old road to the camp and then I walk the last mile or two.

COUNSELOR: And Mr. Devereaux, the head of the deer camp group, knows you're coming?

SAMMY: Nah, but he doesn't mind. We're friends.

COUNSELOR: Well, Sammy, I see a couple of problems. First, our agreement calls for you to not miss daily contact with the ACT team for your first 30 days and for you to not miss NAMI meetings. Second, I think we at least need to talk to Mr. Devereaux and let him know you're planning to go out to the camp, how long you'll be there, how you would get into the building, that sort of thing.

[Sammy agrees to give Mr. Devereaux a call in Mike's presence. Mr. Devereaux greets Sammy warmly, but reminds him that he left the deer camp "in a mess" and that he can only return when others are there and the mental health center has given its approval. Following the call, Mike and Sammy agree that Sammy will defer the visit to the camp for a few months. Sammy is disappointed but accepts the decision. Mike acknowledges Sammy's disappointment and supports his

trying to make it work by clearing it carefully with Mr. Devereaux as well as his continuing participation in his recovery efforts.]

Three months later (follow-up)

Sammy has been active in NAMI now for 3 months. Working with the ACT team, he has managed to balance the amount of medicine he takes so that it can control his symptoms while not making him feel "dopey." Mike is tapering off his involvement with Sammy, transitioning responsibilities to the ACT team. Sammy has made a couple of friends through the NAMI Recovery Program and, with the help of the ACT team, has found part-time employment with a local moving company. He is also planning to enroll in a course on electronics repair at the community college next month. A core element of his recovery has been his ability to maintain supported housing, which gives him an element of independence yet continues his access to treatment. The combination of PATH support, supportive housing, mental health services at CMHC, NAMI rehabilitation services, and interim financial support has given Sammy a strong foundation for recovery.

Summary

Sammy has a history of SMI and was at significant risk of relapse before adequate supportive housing was made a part of his recovery plan. It is also essential that he continue to be engaged with local community behavioral health resources, such as the local ACT team and NAMI. He was able to accept temporary housing in a shelter until permanent supportive housing was arranged and, with a supportive landlord and community resources, has made a good transition to the community.

Part 2: An Implementation Guide for Behavioral Health Program Administrators

Part 2, Chapter 1

IN THIS CHAPTER

- Introduction
- Developing Services for Clients Who Are Homeless
- The Housing First Approach
- Challenges in Adapting Programs To Address the Needs of People Who Are Homeless
- Modifying Behavioral Health Services To Meet the Needs of Clients Who Are Homeless
- Interacting With Community Resources To Build a Continuum of Care
- Collaborative Partnerships
- Internet Resources
- Integrating Behavioral Health Services With a Community System of Homelessness Services
- Building Linkages Among Services
- Funding Community Homelessness Services

Introduction

Part 2 of this Treatment Improvement Protocol (TIP) is directed to administrators and senior staff persons and is designed to prepare you to help behavioral health staff persons in their work with clients facing homelessness and the specific challenges that homelessness presents. It can serve as a resource for you to use as you support and challenge your staff to become part of a community-wide response to the problem of homelessness. How can you support your staff members in these efforts? Do they need further training? What additional services and collaborative arrangements does your organization need? Where does funding come from? What do model programs look like?

It is important to emphasize that homelessness is a problem that deserves the attention of behavioral health organizations. Some of the clients your program is currently treating may be homeless or at high risk of becoming homeless within months of their discharge from the program. People who are homeless report more problems related to alcohol use, drug use, and mental disorders than those who are not homeless. Findings from studies of Midwest urban samples of people in shelters, food programs, or living on the street report high rates of problems related to substance use (58 percent of women; 84 percent of men [North, Eyrich, Pollio, & Spitznagel, 2004]; 55 percent of women; 77 percent of men [Forney, Lombardo, & Toro, 2007]).

A meta-analysis of studies done between 1979 and 2007 (Fazel, Khosla, Doll, & Geddes, 2008) revealed a pooled prevalence rate among homeless men for alcohol and substance dependence of 37.9 percent (10 studies) and 24.4 percent (7 studies), respectively. Providing adequate shelter for people who are homeless can be the first step toward engaging in behavioral health treatment. Transitional supportive and permanent supportive housing provided

by either behavioral health programs or other programs in the community have become integral components of recovery promotion in both mental health and substance abuse treatment. (See the online literature review in Part 3 of this TIP for more details.)

Why Is an Implementation Guide Part of This TIP?

Part 1 of this TIP provides the knowledge and many of the tools behavioral health workers in your program will need for working with people who are homeless and those facing the immediate threat of homelessness. But without specific attention to program development, staff support, and specific implementation strategies, the tools your counselors have developed are likely to go unused or will be used ineffectively. Part 2 will give you, in your role as program administrator or senior staff person, ideas and strategies for program development and implementation to support programming for clients in behavioral health treatment who are homeless or at risk of becoming homeless.

Programming for people who are homeless and have behavioral health issues occurs in a variety of settings: criminal justice programs, homelessness programs (e.g., shelters, outreach services, permanent supportive housing services, intensive rehabilitation environments), community assistance programs, community health centers, and other community settings, in addition to more traditional behavioral health programs. Although this TIP is directed primarily at professionals working in more traditional programs, much of the information will also be useful to administrators and senior staff members in other settings serving people experiencing homelessness and substance use or mental disorders.

Developing Services for Clients Who Are Homeless

Your behavioral health program may be interested in serving people who are homeless or at risk of becoming so for a number of reasons, many of which also apply to homelessness programs that want to develop or expand services for clients with mental illness and/or substance use diagnoses.

First, serving people with substance abuse and mental disorders who are homeless often is not a matter of choice. The clients are there! Implementing specific programmatic elements to meet their needs serves to make interventions more successful and cost-effective. It also enables staff to work more efficiently. In this sense, specialized homelessness services are an essential ingredient for quality and effective care in your organization. Many of the clients you serve are not homeless when they come into treatment but, for a variety of reasons, become homeless *during* treatment and have no place to live once they complete intensive treatment. Other clients receiving behavioral health services are just one paycheck or one personal or family crisis away from homelessness. Still others enter treatment because they need shelter. Having a staff with the knowledge and skills to anticipate and address these issues will help your program run more smoothly and with better outcomes.

As the behavioral health field moves toward outcome-based funding, serving clients more efficiently becomes a higher priority. When program staff members are aware of the effects of homelessness on treatment, not only does it lessen problems associated with housing instability; it also reduces the severity of social and behavioral crises that interfere with treatment. This, in turn, increases staff efficiency and client retention.

Additionally, making homelessness services a priority for your program will increase the capacity of the program and the skills of the clinical staff responding to various other social and health needs your clients may have, such as transportation services, health care, financial management, and responses to criminal justice issues. In this sense, programming for homelessness benefits all clients, not just those who are currently or potentially homeless.

Specific services for homelessness may be an opportunity for your program to find additional sources of funding to support client services. A variety of community funding resources are available to address the needs of people who are homeless, particularly those in need of behavioral health services. These additional funding streams can help stabilize your funding base and increase your program's capacity to meet the needs of clients.

Some people in the community may question the costs for intensive and supportive care for people who are homeless and whether the benefits of such care are cost-effective. The reality is that supportive housing is cost-effective when compared with alternatives. The Corporation for Supportive Housing (CSH) report, *Costs of Serving Homeless Individuals in Nine Cities* (The Lewin Group, 2004), presents estimates of the costs of serving people who are homeless in various settings: supportive housing, jails, prisons, shelters, psychiatric hospitals, and acute care hospitals (Exhibit 2-1). Estimates represent the average cost of providing 1 day of service to an individual in each setting and capture the underlying costs of providing services, compared with the payments received from public payers. The CSH report defines supportive housing as a combination of program-building features and personal services to enable people to live in the community.

The Housing First Approach

One of the first decisions you will make in developing services for people who are homeless is whether a Housing First approach is suitable for the clients you expect to serve and for your community. Housing First approaches are used to engage people into services who are homeless and have behavioral health conditions. They are low demand, offer permanent housing for people who are homeless, and do not require the client to enter treatment or document abstinence. Many, though not all, Housing First participants receive Federal disability benefits, and many programs encourage clients to participate in money management programs that ensure payment for housing. Housing First programs provide substance abuse, mental health, and medical services through community case management or multidisciplinary teams. Clients choose which

Exhibit 2-1: Range of Estimated Service Costs per Day by Setting

Setting	Cost per Day
Supportive housing	$20.54 (Phoenix, AZ)—$42.10 (San Francisco, CA)
Jail	$45.84 (Phoenix, AZ)—$164.57 (New York, NY)
Prison	$47.49 (Atlanta, GA)—$117.08 (Boston, MA)
Shelter	$11.00 (Atlanta, GA)—$54.42 (New York, NY)
Psychiatric service hospital	$280 (Phoenix, AZ)—$1,278 (San Francisco, CA)
Acute care hospital	$1,185 (New York, NY)—$2,184 (Seattle, WA)

Ranges established across: Atlanta, GA; Boston, MA; Chicago, IL; Columbus, OH; Los Angeles, CA; New York, NY; Phoenix, AZ; San Francisco, CA; and Seattle, WA.

Source: The Lewin Group, 2004.

services to receive. More information about these programs is available on the Corporation for Supportive Housing Web site (http://www.csh.org).

Housing First programs demonstrate substantial enrollment into services and housing stability for individuals who are chronically homeless and have long-standing mental illness and, in most cases, substance use disorders (Pearson, Locke, Montgomery, Buron, & McDonald, 2007). Enrollment status is determined more by continued contact with case managers and other service providers and less by whether the client is continuously residing in program housing. Temporary departures from housing are not uncommon; program staff continue to follow up with clients even when they are away from their housing. Many programs hold units for up to 90 days and encourage clients to return.

Housing First programs range from scattered-site independent housing leased from private landlords (thus increasing individual choice in both housing and neighborhoods) to congregate living programs in which the program owns or controls the housing (allowing staff to provide a high level of onsite supervision and response to client crises). Staff members are available around the clock to help clients maintain their housing and meet their other needs.

Implementing Housing First models in suburban or rural areas can present challenges that require modifications to the model. Staffing may need to be composed of smaller teams resembling assertive community treatment (ACT) teams, which maintain low caseload ratios and broker some services from community providers. Teams can feature interdisciplinary staff from different organizations. Resources may be needed to purchase or use extra vehicles. Housing choices may be restricted to renting a room in someone's home, sharing a house, or waiting until a single unit is found. (For descriptions of Housing First programs, see U.S. Department of Housing and Urban Development [HUD], 2007b.)

Communication among staff members is often accomplished through daily team meetings so that they can respond immediately to client needs. Many programs also have automated documentation services for collecting information on client status and outcomes.

Funding for Housing First programs comes from diverse sources. The programs seek Medicaid reimbursement for mental health case management services and State or county funding for clinical services. Additional sources of funding might include foundations and other private sources. HUD assistance programs provide rental assistance. State or local funds may cover short-term stays in a hotel while a client seeks housing, or rental assistance may be provided to clients who are ineligible for HUD assistance programs.

These programs often use a representative payee system to handle clients' income. This is a money-management system that assigns a third party to handle disbursement of funds for individuals receiving Supplemental Security Income or Social Security Disability Insurance (American Association of Community Psychiatrists, 2002). It is often a practical need and helps people develop independent living and money management skills.

Many Housing First programs strongly encourage representative payee arrangements for certain clients. People with representative payees at baseline are more likely to stay housed (HUD, 2007b). Although representative payee arrangements can be a valuable intervention for individuals who are severely disabled, you and your staff should carefully consider potential consequences of removing client responsibility for deciding how and when to spend

money. Power struggles can result when a client's request for money is denied to cover higher priority needs (e.g., when the request conflicts with paying rent). One way to reduce power struggles is to have personnel other than the counselor act as the "banker," permitting the counselor to work more effectively with the client on money management skills. For more on representative payee arrangements, see the Social Security Administration's Web site (http://www.socialsecurity.gov/payee/).

Unless you do adequate groundwork, the process of establishing a Housing First program may run into unexpected obstacles. First, it is important to separate a client's clinical issues from his or her responsibilities as a housing tenant (Stefancic & Tsemberis, 2007). This may represent a significant change for staff.

One challenge in implementing Housing First programs is the presence of preexisting agency policies that couple housing with requirements that the client maintain abstinence. Rigid, rigorous housing eligibility requirements that often discriminate against clients with psychiatric symptoms or substance abuse can also be challenging. Housing First programs usually accept clients on a first-come, first-served basis.

Another challenge is ensuring collaborative agreements with the immediate neighborhood where any congregate facility is to be located. Steps toward collaboration include:

- Involvement of neighborhood associations or boards on the board of advisors for the program.
- Development of a good neighbor code of conduct.
- Development of shared responsibility in use and maintenance of public resources (such as parks or gardens).
- Rapid response to security or sanitary issues, including police attention.

Challenges in Adapting Programs To Address the Needs of People Who Are Homeless

You may decide to add homelessness rehabilitation services to your existing programming rather than choosing a Housing First approach. When you decide to implement specialized homelessness programming in your behavioral health organization, you will find some special challenges, the solutions to which can be ultimately productive for your program. Still, to institute new services, you must overcome several hurdles.

It is imperative to conceptualize, develop, and implement services for homelessness in the context of your current programming. In effect, the new services need to be natural additions that complement existing programs. Not to do this would mean having a unique homelessness program that is not integrated but rather a separate, isolated entity. In this context, the new service elements have to be conceptualized in response to the question "How can this new service integrate with and complement the services we already offer?"

Second, instituting a new service component for homelessness in your behavioral health program means staff development to confront the myths about people who are homeless, the services they need, and how the services can and should be provided. Staff development may mean additional skills development or enhancing and specializing skills that already exist among staff members, who will need to learn about additional resources in the community and how to collaborate with the organizations and people that provide them. They might need cross-training to work with the specific needs of people who are homeless while maintaining their skills in behavioral

health services. Working with homelessness may require case management and outreach skills unfamiliar to most of the staff. For instance, behavioral health counselors working with clients who have substance use disorders may end up doing outreach with clients who show no interest in changing substance use patterns; mental health workers may feel uneasy at first seeing clients in settings other than their office.

You and your staff will need to interact with a different network of community services. Programs primarily addressing homelessness in the community may have a different orientation to services. For instance, programs for homelessness may have a social service orientation; behavioral health programs, a healthcare-focused perspective. Rehabilitation in homelessness programs may be more oriented to life skills development, whereas behavioral health programs focus on treatment and specific psychological strengths. Thus, community programs created for homeless populations may have different goals, staffing patterns, funding streams, or client goals. Behavioral health program administrators, who often are more experienced in working in the health, substance abuse, and mental health fields, should recognize these different perspectives and view them as strengths, not impediments.

In addition to formal relationships among organizations, an informal system of community involvement, interorganizational relationships, and services planning is required to bridge gaps between traditional behavioral health and homelessness services. Later in this chapter, the discussion of collaborative partnerships and service modification highlights this issue.

Special Needs of Behavioral Health Clients Who Are Homeless

Most clients who are homeless and need substance abuse or mental health treatment (and many clients in substance abuse or mental health treatment who enter treatment without housing or become homeless during treatment) have needs distinct from those of other clients. Some problems may resemble those experienced by many clients but differ in severity and incidence. These problems extend beyond lack of housing and include psychiatric impairments, drug use, financial mismanagement, criminal justice issues, and healthcare needs. Thus, special program elements may need to be developed. These include outreach and client retention programs, specialized case management efforts, and treatment planning and approaches that integrate life skills development and specialized resources for relapse prevention and recovery promotion.

Different Clients, Different Needs

The three groups of clients who are homeless, as defined in Part 1, Chapter 1, present different needs to your program. Some clients are homeless for the first time in their lives. Your program needs policies and procedures to guide counselors and clinical supervisors in helping in these emergencies. Clients who are transitionally homeless and are recovering from substance use disorders may benefit from transitional living facilities, such as Oxford Houses, described in Part 1, Chapter 1, of this TIP. Most communities have a variety of established resources for clients who are transitionally homeless. For instance, the Salvation Army, along with other faith-based resources, offers services for the transitionally homeless in many communities. These resources are especially valuable for families facing the crisis of first-time homelessness and can serve to prevent the development or exacerbation of other psychosocial and health problems.

Clients who are episodically homeless need clinical workers who recognize and focus on the stressors that caused the homeless episode. Administrators need to have established

linkages with such community resources as vocational rehabilitation, employment resources, financial and health services, and other community resources so that people who are episodically homeless can quickly get back on their feet once they are stabilized and on a recovery path. It is useful for administrators to have open conduits to local entitlement agencies (e.g., Social Security, public assistance) and to ensure that counselors are well trained to negotiate these systems to help clients in crisis obtain or maintain the financial supports to which they are entitled.

Clients who are chronically homeless are often the most visible subgroup of people experiencing homelessness in a community. They also may be beset with the widest variety of co-occurring mental health, health, financial, criminal justice, and employment issues in addition to their homelessness. Seldom is a community behavioral health program capable of addressing all of the needs of people who are chronically homeless; thus, they must depend on linkages with housing, medical, entitlement, and other resources to begin to bring stability to the lives of these clients.

Regardless of the housing status of your program's clients at intake, it is important to build in resources for eliciting housing information early in treatment to ensure that potential or actual homelessness does not present as a crisis when a client prepares for discharge.

Modifying Behavioral Health Services To Meet the Needs of Clients Who Are Homeless

To serve people who are homeless, your organization can adapt its programs to provide services that were not previously available. These service modifications to meet the needs of people who are homeless take different routes based on knowledge about the target population. A bottom-up approach to service modification (described below) begins by evaluating the needs of the people who will receive the services. In a top-down approach, the impetus for change comes from administrators, boards of directors, funding resources, and the like. If you are unfamiliar with your community's homeless population, a bottom-up approach is best; top-down integration works best when you know the population well and can assess in advance the major barriers to care and the broad initiatives needed to overcome them. Top-down modifications often require some bottom-up information to make the right choices. You can tentatively commit to a plan but then engage in community discussion before acting, making modifications as necessary.

Bottom-Up Service Planning

Bottom-up service planning is a process of using peer workers, case managers, clinicians, supervisors, and administrators to develop a program that meets identified needs of a special client population. It often starts with a few unique, complex cases—for example, developing services for people who often use emergency shelters, emergency rooms (ERs), or detoxification centers. The project scale increases incrementally as effective practices are established and resources become available. The first stage of bottom-up service integration is to identify the target population and engage people in services and then develop feedback mechanisms to identify what works and how to improve program efficiency. Ask people from the target population about their priorities informally or via surveys or focus groups. The National Health Care for the Homeless Council Web site (http://www.nhchc.org/advisory.html) offers a manual for involving a formal consumer advisory board.

Collaborating with partners to identify and engage the target population

Bottom-up service modification can be a collaboration between nongovernmental organizations (NGOs) or between programs within an NGO. The first step is small but dynamic: collaborating with other service providers who can help identify your target population and introduce you to new clients. These collaborations can be informal or formal. Documentation at this stage is simple: tracking where people are identified and their progress through the system. Exhibit 2-2 lists some helpful elements in bottom-up modification.

How do you perform bottom-up services modification?

Step 1: Perform a needs assessment. The needs assessment includes gathering data not only on the demographics and expressed needs of the homeless population to be served, but also on how those services can be most effectively delivered, which services seem to result in client change, and which services can be offered over time (see needs assessment steps listed on p. 164).

Step 2: Get internal buy-in. Take your needs assessment to the CEO, chief clinical officer, and/or board members and develop a plan for how to proceed that includes identifying potential funding sources, stakeholders, staff members, and services that can reasonably be added to drive the initiative.

Step 3: Make contact with funding sources. Organization administrators seek funding to meet the needs of the population. Once the possibility of funding exists, go to Step 4.

Step 4: Identify stakeholders. Identify other participants in your effort, begining with your clinical staff and fellow administrators. Other

Exhibit 2-2: Key Components for Bottom-Up Modification

1. **Sense of urgency.** Frontline staff may fear that failing to engage people in services will lead to victimization on the streets, untreated physical illness, or deteriorating life situations. This fear propels the staff into a sense of urgency about helping people get the services they need.
2. **Support personal responsibility.** Clinical supervisors and administrators support the frontline staff in embracing personal responsibility for the advocacy for each case. This includes understanding the staff's experiences and providing flexible support (e.g., willingness to modify team structures) so the staff can more easily accomplish its work.
3. **Negotiate, collaborate, and advocate.** Frontline staff members, supervisors, and administrators who are committed to providing services to the target population negotiate, collaborate, and advocate with other service providers to meet each client's needs. Interorganizational partnerships facilitate this through joint supervision of day-to-day activities.
4. **Hold weekly frontline staff meetings.** Case managers, clinicians, and supervisors meet weekly to capture the collective wisdom gained in this learning process and channel their enthusiasm into understanding how to do the work effectively. They discuss and develop methods to address missed opportunities to connect with other service providers and potential clients.
5. **Hold monthly administrator meetings.** You and other administrators discuss the learning process and set principles of practice and procedures as needed (e.g., through case descriptions, understanding barriers to services and missed referrals, advocating for access to services on a case-by-case basis with State administrators). You'll gain a better understanding of the work by meeting clients and providing some direct services.
6. **Include appropriate partners.** As you identify new service needs and resources in your organization or in the community, include appropriate partners in the learning process.
7. **Obtain new funding resources.** New funding allows the project to serve more clients.

Sources: Rowe, Hoge, & Fisk, 1996, 1998.

potential stakeholders include:

- Your board of directors.
- The local continuum of care (housing providers; mental health, substance abuse, and medical treatment providers; hospital emergency departments; and staff members of criminal justice programs).
- Local business owners and legislators with whom your organization has strong relationships.
- Program alumni and other community supports (e.g., faith-based institutions).
- Community boards.
- Private foundations for matching funds.

Step 5: Create and formally present a concept paper. A strong grant-writing team or consultant creates the concept paper. Critical issues to address include:

- A clearly articulated problem statement, proposed plan, implementation process, timeline, and evaluation process. Describe the problem using a combination of statistics and short personal stories.
- How the resources you are seeking fit your organization's mission/strategic plan.
- The roles to be played by your partners.
- If you are seeking private funding, a plan for transitioning to public funding.

Step 6: Conduct postpresentation activities. Homelessness is a politically charged issue; handle contacts with funders with tact.

Step 7: Receive funding. Designing and funding your initiative ends; implementation begins.

Adapting clinical services to meet the needs of the target population

At this stage, you and the clinical staff learn to adapt clinical practices to meet the needs of clients and influence institutional policy. Focusing on individual cases of homelessness makes it easier to understand the context of counselor–client work and the barriers to doing the work. For example, counselors in a detoxification program (in the same organization as an intensive substance abuse treatment program) request case-by-case exceptions for people who are homeless to a policy barring readmission of clients within 30 days of discharge. In each case, the counselors argue that the policy is a barrier to rapid readmission to substance abuse treatment, which would reduce the relapse severity and the length of treatment needed by the client. As the cases brought to the administrator accumulate, he or she eventually changes the policy.

As project scale increases and clients engage, you will identify other components of care:

- Frontline staff note good collaborative experiences with some NGOs, whereas others do not meet the expected clinical standards when working with people in intensive substance abuse treatment who are homeless. Referrals are withheld from the latter, which may stimulate development of more flexible services in the community and a corresponding increase in referrals. Counselors, case managers, and supervisors realize the need for service and policy modifications to better meet the population's needs. For example, after observing that some people feel isolated when placed in their own apartments, create an alumni program to facilitate connection to community recovery supports and help people successfully transition to permanent housing.
- Documentation and use of surveys and feedback loops become more sophisticated and formalized to enable sharing of information with funding sources and State authorities.
- As clinical and administrative leaders formalize the integration of people who are homeless into the organization and the treatment system, their bottom-up efforts lead, directly or indirectly, to top-down integration opportunities.

Top-Down Service Modification

Top-down service modifications work when you are familiar with the target population and can assess and overcome the barriers to care. You can develop service modifications through negotiations with other providers within and across service systems. Such strategies are informed by bottom-up processes, such as solving dilemmas that arise in frontline work.

How do you perform top-down services modification?

Step 1: Allocate money. A request for proposals is issued or a service need is identified.

Step 2: Identify stakeholders/collaborators.

- Identify stakeholders—representatives of local governments, businesses, employers, recovery communities, and other service providers who will want to refer clients to your program.
- Identify partners—outreach teams, housing providers, mental health treatment providers, vocational and recovery service providers, financial and health benefit providers, and primary healthcare providers who want to develop new capacities in existing programs or create new interagency programs.
- Identify the scope of the project and the role of each partner.
- Get letters of support from partners, recognized advocacy groups, and other stakeholders.

Step 3: Find local or regional resources to help you develop the program. Bring in resources as needed to help you define the services you wish to provide, the adaptations your program will need to make, and a timeframe for implementing services.

Step 4: Write a proposal or concept paper. Include a budget; bring all collaborators to the table.

Step 5: Implement the plan once a contract is awarded.

- Hold an upper-level advisory and implementation meeting:
  - Administrators involved in the partnership (interorganizational) or programs (intraorganizational) meet and identify what needs to be done, what needs further investigation, and who will be responsible for doing so.
  - A memorandum of understanding (MOU) or memorandum of agreement (MOA) between the NGOs (interorganizational only) is drafted and describes tasks and roles. (A sample MOU appears in Part 2, Chapter 2.)
- Assemble an implementation team:
  - During the startup period, program directors work together to coordinate services.
  - The team identifies other committees (e.g., screening, case management) and persons (e.g., consumers, senior clinical staff members, line counseling staff members, peer counselors, program evaluators) to be involved in administering the project.
  - The team addresses confidentiality agreements, admission criteria, and intake forms.
- Form a team of service providers; define their roles. Staff members from collaborating programs create a core team to provide services and cross-train and educate each other about their programs, organizations, and roles. Potential members include:
  - Peer counselors.
  - Outreach workers.
  - Case managers.
  - Substance abuse and mental health treatment counselors.
  - Team leader(s) who collaborate with peers in other NGOs, provide some clinical services and supervision, and are trained to work with people who

have been diagnosed with co-occurring disorders (CODs).
  - Consultants on medical and mental health needs of individuals who are homeless who facilitate petitions for involuntary transport and hospitalization when necessary.
  - Liaisons to detoxification services, criminal justice, and financial and health benefits.

Step 6: Schedule regular interorganizational meetings. Address policies and procedures that inhibit service provision to people who are homeless. Regular working groups can include:

- Advisory board. Upper-level managers from each collaborating organization or the head administrators from each organization to be involved in proposal creation, addressing outcome measures, data, reports for the funder, and the like.
- Client selection committee. Midlevel clinical/program directors from each organization.
- Interorganization/interdisciplinary clinical case management team. Direct service staff meet weekly to discuss new admissions, people in transition, and particularly challenging cases.
- Stakeholder advisory group. Keeps community stakeholders aboard as program starts.

Example of successful service modification: Health Care for the Homeless

In practice, programming changes often combine bottom-up and top-down strategies. Health Care for the Homeless (HCH) in Baltimore, MD, provides an excellent example of this combination, which results in comprehensive services provided when the client is ready.

Bottom-up service modification

Begun in 1985 as a small triage and outreach unit, HCH is now accredited by the Joint Commission on the Accreditation of Healthcare Organizations. By adding programs as needs were identified, HCH now offers a broad range of services: street outreach, primary health care, mental health services, intensive outpatient substance abuse treatment, medication-assisted treatment, and referrals to residential treatment. A bottom-up modification resulted from an analysis of intakes that revealed that people purchased buprenorphine on the street when they could not access detoxification services. This suggested a need for a buprenorphine initiative to improve engagement and treatment retention. Funding for a nurse and case manager was sought and won, but for only one position. A nurse/case manager was hired for a caseload of five clients daily. When he left, a substance abuse case manager was hired and an agreement was created with the health center staff to administer and store the medications.

Top-down service modification

A top-down modification was prompted by requirements from funding sources that influenced the length of service delivery and program development. Separate funding streams for mental health (mostly third-party billing systems) and substance abuse treatment services (mostly public funding and grants) created differences in approaches to service delivery. Federal requirements for more formal data and reporting mechanisms led to State service outcome benchmarks for the substance abuse treatment program that focused heavily on abstinence, program use, and retention. To meet these benchmarks and the engagement needs of people who are homeless, HCH created a pretreatment phase supported by the City of Baltimore. People in precontemplation for substance abuse treatment receive readiness

counseling focused on health education that engages them in treatment at their own pace.

Interacting With Community Resources To Build a Continuum of Care

HUD defines a continuum of care as a local planning process involving the range and diversity of stakeholders in a community in assessing and planning for the needs of people who are homeless. Normally, one superagency is designated as the coordinator of the continuum of care planning process, and one application is made on behalf of the community for HUD funding. "Community" is defined by the continuum of care planning process as the geographic area included in the application. The application is based on assessed needs for three types of housing in the community: emergency shelter, transitional housing, and permanent housing, along with the supportive services needed to address each of these housing needs. One of the features that makes the continuum of care process unique is that it may include nonprofit agencies, governmental agencies, community-based organizations, agencies in the community that provide supportive services (such as mental health and substance abuse treatment programs), local businesses, law enforcement, and consumers who are homeless or were formerly homeless.

Rarely is one program able to meet all of the client's needs, as the continuum of care implies. As a result, collaboration among programs is essential. Although your program's counselors may interact with other agencies at the level of the individual client through outreach, treatment planning, case management, treatment, and follow-up, administrators must work to develop collaborative continua of care, overcome interagency barriers, and ensure that there is "no wrong door" through which to enter services. This is particularly true when addressing the needs of clients who have two or more urgent, severe problems—homelessness and substance abuse or mental illness. Likewise, although a homelessness program may employ behavioral health counselors, they are seldom equipped or funded to provide the full complement of services necessary for comprehensive substance abuse and mental health treatment.

An integrated system of care that provides a continuum of housing services increases communication among the organizations involved, improves coordination among providers, and serves more people who are homeless. Examples of the interrelationship of a continuum of care, organizational strategies for supporting program development and service modification, and strategies for effective service delivery appear later in this chapter. Exhibit 2-3 highlights the benefits of an integrated system of services for people who are homeless.

Collaborative Partnerships

In interacting with other community resources and becoming part of your community's continuum of care, you can establish collaborative partnerships with other agencies that serve substance abuse and mental health clients who are homeless. These partnerships can help your organization expand its range of services, link up with other systems, and foster innovative programming, funding, and community acceptance (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006).

Successful collaboration requires negotiation, compromise, and commitment to address a problem about which all stakeholders experience a sense of urgency and responsibility. An early step in forming partnerships is sharing different perspectives on the problem (e.g., lack of treatment resources versus lack of

Exhibit 2-3: Integrated System of Homelessness Services

Components	Description	Goals
Continuum of Care	A plan and infrastructure of formalized operations and coordinated services provided by multiple organizations. Involves a continuum of care plan, MOUs, sharing of information, resources, and improved access to services.	Collaborate to offer an array of needed services: • Develop procedures that allow for interaction of agencies as needed. • Document the changes in procedures. • Identify and share best practices.
Service Providers	Providers collaborate to secure funding and provide an array of housing, substance abuse treatment, mental health services, support services, health centers, and other services.	Increase effectiveness of services delivered through organizational change processes: • Assess service outcomes and staff skills to deliver services. • Collect information to track and analyze change. • Engage in activities to support change.
Services	Housing, support services, and substance abuse treatment and mental health services are tailored to be responsive to the needs of people who are homeless.	Identify and provide: • Acceptable services and treatment to help people access and maintain stable housing. • Effective strategies for people with complex housing, service, and treatment needs.

Source: Leginski, 2007. Adapted with permission.

appropriate housing stock) and establishing guiding principles or assumptions for the collaboration. Failure to resolve different perspectives can cause covert power struggles. Other barriers to overcome when pursuing partnerships include:

- Competition for scarce resources among community organizations.
- Unwritten policies of daily service delivery.
- Service organizations that resist change.

Creating Interorganizational Partnerships

To address system and service delivery problems with people who are homeless, assess the problem and gather information about the target population and the strategies needed to resolve the problem.

Interorganizational needs assessment

To assess the needs of an interorganizational continuum of care, determine the size and characteristics of the population that is homeless and assess issues raised by community members, governmental agencies, and service providers. One way to start is by talking with other service providers who work with people who are homeless and working with the organization that will apply or has applied for HUD funds. In some localities, a single organization or agency represents the community's needs. The information contained in the "Continuum of Care" application often provides a thorough review of strengths and gaps in the community's services.

Intraorganization assessment

To assess your organization's ability to assist people who are homeless, analyze the number and characteristics of people seeking services who are homeless or at risk of homelessness. Start by counting the number of people who are homeless or at risk of homelessness who are admitted to substance abuse or mental health treatment during a 2- to 4-week period. Other measures include the number of people admitted with criminal justice involvement and the number discharged without employment, job training, or stable housing. This type of assessment includes staff discussion of findings at team meetings to better understand how organizational factors influence findings.

Steps in the assessment process

- Determine the population's gender, ethnic, and racial makeup; criminal justice experience; family status; language; and nature of homelessness (i.e., situational, episodic, chronic).
- Determine whether these characteristics are reflected in the staff providing services.
- Identify gaps in the continuum:
  - Are people not staying in treatment?
  - Are some counselors seeing 1 client who is homeless per month while others see 10?
  - Are clients referred from other services in a coordinated fashion, or are they walking in without referrals?
  - Are clients transitioning out of substance abuse or mental health treatment without employment and housing?
  - Do clients have a primary care provider and affordable access to needed medication?
  - Are some programs in the organization declining referrals because the clients are homeless?
  - Do some programs in the organization have particular difficulty working with clients who have either substance use disorders or mental illnesses?
- Identify policies and procedures contributing to service gaps and consider how to change them; use a formal continuous quality improvement methodology. See the Network for the Improvement of Addiction Treatment's *Primer on Process Improvement* (2008). The Addiction Technology Transfer Center Network (2004a,b) also offers useful publications on the topic.
- Identify issues in the community, such as:
  - More people living on the streets.
  - Legislation that handles homelessness through arrest rather than social services.
  - Insufficient affordable housing stock.
  - Insufficient mental health, substance abuse, and medical treatment services.
- Determine whether this is an opportunity to partner with other providers to improve access to services, create resources to meet the needs of people who are homeless, and reduce costs to the community:
  - If services to address these issues are compatible with your organizational mission and strategic plan, then develop programming.
  - If these services aren't part of your strategic plan or mission, look for community partners.
  - If other providers can't offer needed services, consider developing them in your agency.

Exhibits 2-4 and 2-5 provide information on forming and documenting partnerships.

Exhibit 2-4: How To Develop Partnerships

1. Identify organizations in your community affected by homelessness and NGOs and government entities that already provide services or interact in the community with people who are homeless.
2. Reach out to and become familiar with potential partners (e.g., police, emergency services, businesses, elected officials, neighborhood organizations, health centers); the key to partnerships is finding a shared objective.
3. Agree on a definition of the problem; assess your readiness to partner with them and theirs with you.
4. Form a partnership that benefits both organizations.
5. Define the benefits for each partner.
6. Identify the contributions each organization must make in order to realize these benefits.
7. Sustain partnerships by negotiating agreements that capture the basis of the partnership and the active linkages between partners that allow monitoring of both challenges and successes.

Source: SAMHSA, 2006. Adapted from material in the public domain.

Example of Successful Partnership: Downtown Emergency Service Center

In Seattle, WA, the Downtown Emergency Service Center (DESC) has used partnerships to improve housing services, integrate treatment services, access other community resources, and create innovative housing programming (SAMHSA, 2006).

Internally, DESC integrated its shelter, clinical services, and housing programs. Staff members from each clinical program (i.e., outreach and engagement case managers, substance abuse treatment counselors, and crisis respite program workers) are co-located in the shelter. DESC provides intensive support for housing stability by having one project manager supervise the staff responsible for supportive housing property management and the staff responsible for supportive services. DESC uses information technology to make information about people receiving services available to staff members in different programs. In daily meetings, outreach and engagement, housing, and clinical services staff members discuss new clients and emerging client problems.

DESC partners externally with community services and political organizations. Community partners include the Seattle Department of Social and Health Services, the police department, mental health and drug courts, and the local emergency center. Political partners include the county executive, mayor, and downtown association president. To increase access to benefits for people who can't tolerate the regular process, the staff represents them and works directly with benefit managers,

Exhibit 2-5: How To Document Partnerships

A memorandum of agreement is a written agreement between parties (e.g., NGOs, Federal or State governments, communities, and/or individuals) to work together on a project or meet an objective. An MOA outlines the responsibilities and benefits of each partner. It can be a partnership agreement or a legally binding document that holds parties responsible to their commitment.

A memorandum of understanding is less formal than an MOA. Many NGOs and government agencies use MOUs to define relationships between departments or NGOs and to ensure smooth operations of shared resources and service provision. MOUs can address intraorganizational connectivity, communications, escalations, and response patterns. See Part 2, Chapter 2, for a sample MOU.

resulting in more successful benefit applications. A mutually beneficial collaboration with the police includes offering a standardized program for police trainees to work alongside service providers, making shelter space available as an alternative to incarceration, assisting with safety issues, and meeting regularly to address issues.

DESC provides case management, substance abuse treatment, and mental health and employment services to people referred by the drug court. Shelter staff communicate daily with the ER to increase the shelter's access to emergency medical care. DESC obtains donations from businesses by showing that the housing program decreases the use of emergency services, jail, court, and detoxification, and saves the community money while providing more humane, respectful services for people who are homeless. DESC maintains a strong relationship with political partners by showing that programs effectively meet the needs of people who are homeless and by advocating for policies that facilitate innovative programming, funding, and support. DESC's relationship with political partners supported the creation of an innovative housing and treatment program in Seattle.

Internet Resources

Becoming informed about housing programs is one way you can help your program create relationships with other community agencies serving people who are homeless. A great deal of information is available on the Internet from the following Web sites:

- U.S. Department of Housing and Urban Development: http://www.hud.gov
- National Alliance to End Homelessness: http://www.naeh.org
- Corporation for Supportive Housing: http://www.csh.org
- SAMHSA's National Registry of Evidence-Based Programs and Practices: http://nrepp.samhsa.gov
- National Health Care for the Homeless Council: http://www.nhchc.org
- U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration Information Center: http://www.hrsa.gov
- U.S. Department of Veterans Affairs (VA) Web site on reaching out to veterans who are homeless: http://www1.va.gov/homeless
- VA Web site on health benefits eligibility for veterans: http://www.va.gov/healtheligibility
- National Resource Center on Homelessness and Mental Illness: http://www.nrchmi.samhsa.gov

Integrating Behavioral Health Services With a Community System of Homelessness Services

Across the continuum of rehabilitation services for people who are homeless, a variety of community care providers may be engaged with the client. Some of these services include mental health and substance abuse treatment, housing and rehabilitation services specifically for people who are homeless, general healthcare programs, and other community social and rehabilitation services. Your program may be a small part of the larger services continuum, or may be a major provider of care that spans several of these domains. In either case, it is important that programs have a common goal of quality care for people experiencing homelessness, a recognition that homelessness in the community cannot be addressed by simply providing shelter, and a commitment to and a strategic plan for the coordination and nonduplication of services.

Additionally, there are distinct phases of care for persons who are homeless and are affected by substance abuse or mental illness. These are described in Part 1, Chapter 1, and include engagement, intensive care, and ongoing rehabilitation (McQuistion, Felix, & Samuels, 2008). Two additional transition phases (from engagement to intensive care and intensive care to ongoing rehabilitation) are critical times during which clients may regress from their homelessness rehabilitation, experience a relapse to their substance use or psychiatric symptoms, or drop out of treatment; these phases are therefore important to consider in your community programming.

In a few communities, the entire continuum of care might be offered by one comprehensive program, but it is more likely that different organizations work at different points on the continuum. Be aware of services provided in your community, the scope of the services in an individual agency, and the extent to which outreach and treatment services for behavioral health are provided. This will allow you to identify gaps in services and develop programs to address them.

The phases of rehabilitation form a framework that can guide your decisionmaking about program development, implementation, management, and evaluation. The outline below lists the ways your agency can prepare for and participate in providing services to clients who are in each phase of rehabilitation from homelessness.

Outreach and Engagement

In this first phase of rehabilitation, counselors begin to build and leverage relationships to offer the kinds of help needed by people with substance use and mental disorders who face homelessness. As an administrator, you can:

- Establish collaborative relationships with community organizations.
- Form interdisciplinary teams from several organizations that are coordinated through a single entity. Teams can provide direct access to services that meet client needs and help clients transition from this phase into intensive care. Outreach services that respond to community stakeholders' needs include taking hotline calls from individuals and neighborhood and civic association representatives, in addition to forging strong relationships with local police precincts and ERs.
- Schedule staff members to be off site and available to potential clients.
- Ensure that your staff has the training and experience to perform outreach and engagement and to work with individuals and families experiencing crises related to homelessness. This also entails being aware of community resources for emergency and temporary housing, their restrictions and limitations on services, and their admission requirements.
- Provide funding for practical goods and resources that can be offered to prospective clients (e.g., specific needs of children who live in families who are homeless, battered and abused women and children, people who live on the street).
- Develop tools to document outreach contacts. (See Part 2, Chapter 2, for a sample Homelessness Outreach Contact Form and a sample Daily Contact Log.)
- Provide training for staff members to prepare them for the realities of outreach work (e.g., working outside the office setting; working with individuals and families who are experiencing immediate crises; working with people who want resources but resist or only passively comply with treatment services; tolerating clients who are inconsistent in their contacts and appear one day, then disappear for several days).

- Ensure that your staff is trained in the appropriate interventions for this phase of homeless rehabilitation (such as rapport building) and that staff members are able to rapidly develop case management plans for services.
- Ensure that staff members can recognize signs that a potential client is ready to make a transition to the intensive care phase of homeless rehabilitation or the contemplation stage of change for substance abuse or mental health treatment.
- Provide supervision for outreach workers.
- Provide a forum for discussion of policies and procedures related to conduct and safety on the street and in shelters; formalize policies and procedures (see Part 2, Chapter 2, for samples). Policies should require that staff members work in pairs, carry cell phones, and be able to contact a supervisor when needed. Policies and procedures should require teams to leave situations in which any one member feels unsafe and to choose next steps together.
- Plan and structure critical incident debriefings.
- Discuss steps necessary for quality assurance.

Transition to Intensive Care

This phase begins when the client agrees to accept case management, entitlements, housing, treatment, health care, or other services—or when there is a need for acute medical or mental health treatment. As an administrator, you can:

- Formalize policies and procedures for recordkeeping for potential clients entering the system.
- Provide for delivery of tangible benefits, such as food, clothing, and transportation.
- Enlist help from emergency shelters for pretreatment beds to house clients while they wait for treatment slots.
- Assign case management specialists to provide flexible services, such as housing negotiation, completion of financial and/or health benefit applications, and assistance with using public transportation.
- Provide intensive case management (ICM) and critical time intervention (time-limited ICM) to potential clients as appropriate. These strategies help the agency keep track of clients, help clients stay connected to the agency, and provide access to a variety of services and agencies.
- Offer attractive support services for clients, such as employment, financial and health benefits, and medical and mental health services.
- Offer peer-led services to encourage engagement in services and enhance empowerment and confidence.
- Coordinate transition planning with local agencies, such as jails, hospitals, and substance abuse and mental health treatment programs, to provide housing resources for clients being discharged or released.
- Develop protocols for transition planning.
- Offer transportation to housing for clients exiting jails, hospitals, or treatment programs.
- Ensure that your staff is familiar with your community's housing resources, their requirements, and their limitations.

Intensive Care

Intensive care begins when a person engages in a clinic, shelter, outpatient, or residential treatment program, accepts ACT team services, or obtains transitional or permanent supportive housing (McQuistion et al., 2008). Treatment of substance use and mental disorders and medical conditions is the primary focus during this phase. You can:

- Develop MOAs and MOUs with collaborating housing resources in the community (e.g., programs providing transitional and

permanent supportive housing) so clients do not fall through the cracks in transitioning between or working with two different community systems (housing and behavioral health).
- Provide thorough screening and assessment by behavioral health professionals that includes assessment of substance use and mental health as well as housing needs, financial status, employment status, and other areas of life functioning.
- Fully accomplish active introduction to ongoing and nonemergent general health and wellness services, whether off site with active case management or on site through implementing models of behavioral health and primary care integration.
- Increase engagement and retention by reducing or eliminating waiting time; using peer facilitators, mentors, and senior program participants to orient people to services right after they are assigned to a treatment program; and providing educational sessions for the client's family as appropriate.
- Provide peer mentoring to strengthen connections to recovery supports.
- Develop methods to improve compliance with treatment of substance use, mental illness, and medical disorders and conditions.
- Address, through your programming, the needs of parents with children. Provide services or care for children in your agency or by referral. Offer treatment with a family focus. Assess the safety of children who do not accompany their parents to treatment.
- Ensure that the services you provide are trauma informed. Offer anger management and assertiveness training. Provide training to staff in nonconfrontational methods of addressing conflict and in strengths-based approaches. Offer gender-specific treatment groups (see the planned TIP, *Trauma-Informed Care in Behavioral Health Services* [SAMHSA, planned h]). Be familiar with behavioral health treatment models for people who are homeless and how your community uses those models.

Behavioral health treatment models for people who are homeless

You should be familiar with rehabilitation models for people who are homeless. Your agency may want to partner with other agencies in your community; your staff members may want to be involved with clients from other programs. This section describes three approaches. Assertive community treatment was first used for people with serious mental illness (SMI) at high risk of institutionalization and modified for people who are homeless. HCH is a model program designed to engage people who are homeless into housing, services, and substance abuse recovery. Modified therapeutic communities (MTCs) combine housing and treatment program models.

ACT teams

SAMHSA has designated this evidence-based practice as appropriate for clients who have extensive histories of psychiatric hospitalization, are homeless, have co-occurring substance abuse or medical problems, and/or are involved in the criminal justice system. ACT services are sometimes used in Housing First programs, but ACT teams also function independently of housing programs and are often part of a behavioral health organization. A team-based approach is used to offer substance abuse and mental health treatment, housing, healthcare, medication, and employment services; help with family relations; and recreational opportunities. People can refuse formal treatment without losing housing. Even then, the team visits at least weekly to assess the person's safety, well-being, and living conditions and to keep communication channels

open between the client and the team. On visits, the team notes the person's mental and physical state, follows up on outstanding issues from the last visit, and offers help with whatever the individual wishes to address. The team often helps with routine chores and conveys to the individual that he or she matters to the team (Hackman & Dixon, 2006).

Health Care for the Homeless

HCH combines comprehensive services in a manner that is appealing to people who are homeless. Substance abuse treatment intake, assessment, and engagement occur on a flexible walk-in basis to accommodate clients' difficulty with keeping appointments. Participants who meet the criteria for outpatient or intensive outpatient treatment are encouraged to engage in treatment at HCH. Those needing inpatient medical care, methadone maintenance, or residential treatment are referred to other programs. People too ill to navigate the shelter system are provided shelter and nursing services in a convalescent care program.

Counselors assess for substance use, symptoms of mental illness, housing, criminal justice system involvement, social supports, job interests, work history, and goals, then reframe this information to reflect client strengths and increase motivation to complete treatment and pursue stable employment when possible. Each counselor sees 15 to 20 clients. Each caseload is a mixture of people in various stages of treatment preparedness. Clients receive individual counseling once a week or as often as determined by their recovery plans, including walk-in sessions. The group counseling program is based on the stages of change.

Modified therapeutic communities

MTCs are specialized residential settings staffed by workers who are trained to address both mental and substance use disorders. This model includes a supportive housing component in continuing care.

Following the client's decision to accept MTC services, a structured daily regimen is gradually introduced. Services emphasize personal responsibility and mutual support in addressing life difficulties, peers as role models and guides, and the peer community as the healing agent. Staff and clients create action plans to monitor short-term goals. These goals build as success accumulates, adapt to reflect relapses and return of symptoms of mental illness, and reflect the unique needs and readiness for change of the individual.

At program entry, clients join a housing preparation group and receive other initial services. Staff members build trust, increase motivation, and provide education on homelessness, mental illness, and substance abuse through multiple contacts and a weekly orientation group. The group also strengthens peer affiliations and provides information on program structure and activities.

MTCs operate on token economies. Points are won for behaviors, such as medication compliance, abstinence, attendance at program activities, follow-through on referrals, completed assignments, and activities of daily living. Negative behaviors result in loss of points. Points can be exchanged for phone cards, toiletries, and so forth. Peer facilitators act as role models to encourage the involvement of people who are newly admitted, build hope, and plan for the future.

Teaching vocational and independent living skills is a key part of an MTC program. Vocational activities begin shortly after entry, and work experience begins in a peer work group. Vocational exploration and work readiness assessments detail client work history, interests, attitudes, and ability to find a job (e.g., applications, interviewing, interpersonal relationships).

Basic vocational skills training in maintenance, clerical, and inventory tasks are taught, with weekly job assignments and peer group review.

Interested individuals who show commitment to the program, personal progress, and ability to help others are recruited into peer counselor training near the end of residential treatment. They get didactic and practical experience as role models, group facilitators, and counselors and attend briefing and debriefing sessions before and after each group and activity. The supervisor or program director provides supervision each week and a written evaluation each month, and other staff members, assisted by senior trainees, run weekly peer counselor training groups. Trainees are paid a stipend. Those who successfully complete both peer counselor training and the MTC residential program can become counselors in the MTC or comparable programs.

Transition to Ongoing Rehabilitation

This transition is gradual and is a high-risk time for dropout and/or relapse. Much of the programming that behavioral health programs can undertake at this phase relates to building recovery skills, reducing relapse risks, and encouraging participants to increase their involvement in the community through 12-Step programs and other community support efforts. Transitional housing for individuals leaving intensive behavioral health treatment, as described in Part 1, Chapter 1, may become a primary support for the transition to ongoing rehabilitation. Halfway and ¾-way houses for individuals graduating from intensive behavioral health treatment and Oxford Houses for people recovering from substance use disorders are examples of housing resources that can benefit individuals making the transition to ongoing homelessness rehabilitation. To make your program most effective at this stage, you can:

- Facilitate staff efforts to plan for discharge from substance abuse or mental health treatment for clients facing homelessness.
- Plan for clients' ongoing medical and rehabilitation needs, including continuing care, relapse prevention training, support services, transportation, and other recovery supports (see the planned TIP, *Recovery in Behavioral Health Services* [SAMHSA, planned e]).
- Include ICM and other evidence-based practices that support recovery.
- Maintain agency contacts with the housing network, particularly transitional supportive and permanent supportive housing.
- Facilitate connections in the community that could provide opportunities for clients to obtain paid or volunteer work.

Ongoing Rehabilitation

In this open-ended stage, the client self-identifies as no longer homeless, sustains and further incorporates changes made in intensive care, and works to avoid relapse (McQuistion et al., 2008). Administrators can:

- Support staff members as they continue to devote time to clients in ongoing rehabilitation and abstinence (e.g., by helping clients establish roles in the community).
- Provide a means for clients to contact the agency in case of a relapse to substance use, a return of symptoms of mental illness, or a crisis in housing.
- Provide ongoing support for clients, including regular follow-up meetings or phone calls.

Service approaches—model programs

Permanent supportive housing

Permanent supportive housing for persons with psychiatric disabilities offers individuals who are homeless, at risk of homelessness, or precariously housed an opportunity to obtain

and maintain a residence in the community. The residence can be a single-occupancy house or apartment (scattered-site housing) or single-site housing, in which residents share apartments in a single building or cluster of buildings. Permanent supportive housing offers people the opportunity to be integrated within the larger community, to have a home of their own, and to have choice in where and how they live.

SAMHSA's *Permanent Supportive Housing Evidence-Based Practices (EBP) KIT* (2010) lists 12 elements of permanent supportive housing programs that form the core guiding principles of these programs and differentiate them from other forms of housing assistance. The 12 elements are:

1. Tenants have a lease in their name; thus, they have full rights of tenancy under landlord–tenant law, including control over living space and protection against eviction.
2. Leases do not have any provisions that would not be found in leases held by someone who does not have a psychiatric disability.
3. Participation in services is voluntary, and tenants cannot be evicted for rejecting services.
4. House rules, if any, are similar to those found in housing for people without psychiatric disabilities and do not restrict visitors or otherwise interfere with life in the community.
5. Housing is not time limited, and the lease is renewable at the tenant's and owner's option.
6. Before moving into permanent supportive housing, tenants are asked about their housing preferences and are offered the same range of choices as are available to others at their income level in the same housing market.
7. Housing is affordable; tenants pay no more than 30 percent of their income toward rent and utilities, with the balance available for discretionary spending.
8. Housing is integrated. Tenants have the opportunity to interact with neighbors who do not have psychiatric disabilities.
9. Tenants have choices in the support services they receive.
10. As needs change over time, tenants can receive more intensive or less intensive support services without losing their homes.
11. Support services promote recovery and are designed to help tenants choose, get, and keep housing.
12. The provision of housing and the provision of support services are distinct.

The ultimate goal of permanent supportive housing is to reduce discrimination and social stigma experienced by people with psychiatric disabilities; to offer choice in housing and de-emphasize institutional and custodial care, which invites withdrawal from family and the community; and, especially, to reduce relapse leading to the need for specialized intensive mental health treatment. Several types of rental assistance can be provided through permanent supportive housing, including:

- Project-based rental assistance: Housing subsidies are tied to a specific housing unit.
- Sponsor-based rental assistance: The tenant leases a unit owned by a nonprofit group that rents to people qualified for the program.
- Tenant-based rental assistance: Qualified tenants receive a voucher that can be applied to rent in a housing unit that agrees to accept the voucher for part of the rent.

Oxford Houses

The Oxford House movement began in 1975 in Silver Spring, MD, with the establishment

of a house, in a residential neighborhood, for persons in recovery from substance use disorders. The houses are democratically run by the residents and are drug free. There are now more than 1,200 houses throughout the United States. Each house operates under the guidelines of the Oxford House World Council and is guided in its operation by the *Oxford House Manual*. Some houses are exclusively for men or for women; others accept both sexes. A few houses operate exclusively for individuals with children who also reside in the house. Participation in 12-Step and other community change resources is strongly encouraged. Though most residents stay less than 2 years, there is no fixed time for residence. Individuals can live in the house as long as they share in the rent and share in the operation and maintenance of the house. For more information on Oxford Houses, see Part 1, Chapter 1, of this TIP or the organization's Web site (http://www.oxfordhouses.org).

Building Linkages Among Services

Individuals facing homelessness deal with multiple stressors in their lives. In many communities, services to address these stressors have historically been segregated, making it difficult for the client to access and use them. The lack of access to primary healthcare services can be a major difficulty. In recent years, however, community health centers have become an integral component of healthcare delivery for individuals and families affected by homelessness. Some community health programs provide only primary healthcare services, but others have expanded to outreach, behavioral health, health promotion, and other activities.

Federally Qualified Health Centers

The "Federally Qualified Health Center" (FQHC) designation is given by the Health Resources and Services Administration and the Centers for Medicare and Medicaid Services to nonprofit public or private clinics that provide care to medically underserved areas or populations. FQHCs provide a comprehensive range of primary healthcare, behavioral health, and supportive services to patients regardless of ability to pay. A key function of FQHCs is thus to provide care to people who are homeless in their communities.

These centers are supported in part by grants from the Community Health Center program. Some, in communities that have high rates of homelessness, may receive Federal HCH Program grants; in fact, some FQHCs are supported solely by these grants.

The HCH care delivery approach involves a multidisciplinary integration of street outreach, primary care, mental health and substance abuse treatment, case management, and client advocacy. Coordinated efforts between FQHCs and other community health service providers and social service agencies characterize this approach to serving homeless populations. According to the National Academy for State Health Policy, the ability of these coordinated efforts to improve the quality and efficiency of care is increasingly important, given the emphasis in healthcare reform legislation on consolidated, integrated care (Takach & Buxbaum, 2011).

The National Association of Community Health Centers (NACHC) offers technical assistance to all HCH health centers. For resource materials relevant to the provision of care to people who are homeless, visit their Web site (http://www.nachc.com/homeless-healthcare.cfm).

It is critical that behavioral health programs providing services to people who are homeless coordinate their services with community healthcare and other primary healthcare providers. Clients facing homelessness may enter the system through a variety of doors, and the locus of care may depend in part on primary symptoms exhibited by the client. An integrated approach, however, remains essential to quality care.

Clients may enter the system in primary healthcare settings, State psychiatric hospitals or jails, community substance abuse treatment facilities, or community mental health centers, but should have access to care for primary health, substance abuse, and mental health services regardless of entry point. Depending on the symptom presentation, clients may have one predominant need at the point of entry to the system. Symptom severity may define how services are provided, but the important element of integration of care exists throughout the range of services available.

Integrating Other Community Support Services

Most individuals recovering from both homelessness and a mental and/or substance use disorder need a variety of supportive services, especially in early recovery. Permanent housing is not sufficient to address the urgent needs they experience. The supportive resources provided by a variety of community agencies are essential. As opposed to the typical experience in institutional settings, clients in permanent supportive housing always have a choice in which supportive services they will use. Additionally, the services offered need to be tailored to the unique needs of the individual client. Some people in recovery might need transportation, whereas others need case management services to orchestrate their path through a maze of social services. Still others may need financial management, including a designated payee to help handle their income and expenses; others may benefit from peer mentoring. Most will need a variety of supportive services. Contrary to their past experiences, individuals entering permanent supportive housing can choose which services they will use.

SAMHSA's *Permanent Supportive Housing Evidence-Based Practices (EBP) KIT* (2010) lists several domains of relevant services, including:

- Services to support housing retention, such as helping clients understand their rights and obligations as renters in the program, crisis intervention, using peer mentoring and support groups, and developing recreational and socialization skills.
- Independent living skills, including communication skills, conflict management skills, budgeting, personal hygiene, and housekeeping.
- Recovery-focused services, such as participating in recovery support groups, becoming an advocate for mental health and substance abuse recovery, and being a peer mentor to new clients entering permanent supportive housing.
- Community integration services designed to help the individual become part of the larger community and thereby develop a sense of belonging and connection to the neighborhood and the larger community through participation in community events, such as recreational activities, spiritual programs, community educational activities, and community events.

Other service domains include involvement in traditional community support programs, which can include:

- Mental health services.
- Substance abuse treatment.
- Health and medical services.
- Vocational and employment services.
- Family services.

Funding Community Homelessness Services

Various community, State, and national resources provide funding for homelessness services. These funding sources may be private foundations, government entities, or community groups. Only rarely can health insurance be a reliable funding source for homelessness services. Funding may be for "bricks and mortar," for provisions such as food or clothing, or for the targeting of specific needs, such as substance abuse treatment, mental health services, primary health care, or case management. One place to start with program development is to survey what resources for homelessness exist in your community, what services those resources provide, and who offers the funding for available services. Ideally, services should arise from identified community needs (bottom-up planning); however, it is not uncommon that services arise from available funding (top-down planning) or a combination of both.

Federal funding for homelessness services can be divided into two major categories: direct funding for housing and funding for services that support individuals who are homeless. The primary source of direct funding for housing is HUD. In fiscal year 2011, $1.63 billion was available for Continuum of Care (CoC) grants. CoC programs are based on community needs assessment and have a goal of helping individuals and families who are homeless quickly transition to self-sufficiency and permanent housing. In a CoC community, a local or regional planning board coordinates funding for housing and homelessness services for the geographic area. Local programs seeking funding apply jointly with other community programs in a single application to HUD. The four primary components of CoC are:

- Outreach, intake, and assessment.
- Emergency shelter to provide immediate and safe alternatives for people who are homeless.
- Transitional housing with supportive services.
- Permanent supportive housing.

The four primary programs available to provide these services are:

- Supportive Housing Program, now part of the Continuum of Care program.
- Shelter Plus Care Program, now part of the Continuum of Care program.
- Section 8 Moderate Rehabilitation Single Room Occupancy Program.
- Dwellings for Homeless Individuals (Section 8/SRO) Program.

Other HUD-sponsored housing programs include:

- Base Realignment and Closure.
- Housing Opportunities for Persons With AIDS Program.
- Veterans Affairs Supportive Housing Program.
- Disaster Housing Assistance Program.
- Housing Choice Voucher Program (Section 8).
- Public Housing Program.
- Section 202 Supportive Housing for the Elderly Program.
- Section 811 Supportive Housing for Persons With Disabilities.

Additionally, a variety of funding is available for supportive services for individuals and families who are homeless or at risk of homelessness. Some of these programs can also fund housing services, but often only on a temporary or transitional basis. In addition to HUD funding for services, programs from HHS, VA, the U.S. Department of Justice, and the U.S. Department of Labor contribute substantial funding to address homelessness.

Projects for Assistance in Transition from Homelessness (PATH) is a SAMHSA-supported formula grant program to provide homelessness services for people with serious mental illness, including those with co-occurring substance use disorders. The program provides funding to all 50 States and the U.S. Territories and possessions through almost 600 local agencies. Services include community-based outreach, mental health and substance abuse treatment, case management and other support services, and limited housing options. Application for funding is made through each State's Single State Agency designated to manage PATH funding. The services provided in a particular State depend on that State's needs. For instance, in rural areas, funding may be available for outreach in areas where homelessness services have not traditionally been available. Some States have support programs for special populations with SMI. Other States coordinate services with local community mental health centers to ensure that individuals who are homeless or at risk of homelessness receive comprehensive care for mental illness or CODs. PATH monies are also available for training local providers on effective strategies to assist people with SMI who are homeless.

Other programs available through HHS for persons and families who are homeless include:

- Health Care for the Homeless. This multidisciplinary, comprehensive program provides primary health care, substance abuse treatment, emergency care with referrals to hospitals for inpatient care services, and outreach services to help difficult-to-reach people who are homeless establish eligibility for entitlement programs and housing.
- Services in Supportive Housing (SSH) (SAMHSA). The SSH program helps prevent and reduce chronic homelessness by funding services for individuals and families experiencing chronic homelessness and living with a severe mental and/or substance use disorder. Grants are awarded competitively for up to 5 years to community-based public or nonprofit entities. Services supported include, but are not limited to, outreach and engagement, intensive case management, mental health and substance abuse treatment, and assistance with obtaining benefits.
- Grants for the Benefit of Homeless Individuals (GBHI) (SAMHSA). GBHI is a competitively awarded grant program that helps communities expand and strengthen their treatment services for people experiencing homelessness. Grants are awarded for up to 5 years to community-based public or nonprofit entities. Funds may be used for substance abuse treatment, mental health services, wrap-around services, immediate entry into treatment, outreach services, screening and diagnostic services, staff training, case management, primary health services, job training, educational services, and relevant housing services.

VA provides a variety of programs to assist veterans who are homeless. In cooperation with HUD, VA provides permanent supportive housing and ongoing case management services for veterans who require those supports to live independently. HUD has also allocated more than 20,000 Housing Choice Section 8 vouchers to Public Housing Authorities throughout the country for eligible veterans who are homeless. The Housing Choice Section 8 vouchers program is particularly beneficial to female veterans, veterans recently returned from overseas, and veterans with disabilities. Housing is permanent and accompanied by supportive services; the voucher is portable, allowing users to move to different locations or get better housing solutions as they become available.

VA also funds community-based agencies to provide transitional housing and supportive services for veterans who are homeless through the Capital Grant Component program. For more information on this program and the Homeless Providers Grant and Per Diem Programs, contact Jeff Quarles toll-free at 1-877-332-0334.

Stand Down programs, located throughout the United States, are developed and operated by veterans service organizations, local CoC programs, community groups, military personnel, and other interested citizens to provide shelter, meals, clothing, employment services, and medical care for veterans who are homeless. Normally, Stand Down programs are time limited (1–3 days). VA funding is available for up to $10,000 to conduct events each year.

The Interagency Council on Homelessness and the HEARTH Act

The United States Interagency Council on Homelessness (USICH) is an independent agency of the Federal executive branch and is composed of 19 Cabinet Secretaries and agency heads. Its mission is to coordinate the Federal response to homelessness and to work with State and local governments and the private sector to end homelessness in the Nation. The blueprint for this monumental task is provided in USICH's strategic plan, *Opening Doors* (http://www.usich.gov/opening_doors/). The plan calls for heightened dedication to solving the problem, with an emphasis on increasing economic security, improving health and stability, and returning people experiencing homelessness to safe housing as soon as possible. The Council was established by the Stewart B. McKinney Homeless Assistance Act of 1987 and was reauthorized by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, which amends the McKinney-Vento Act.

Under the HEARTH Act, programs for housing assistance were consolidated as follows:

- The Shelter Plus Care Program, Supportive Housing Program, and Section 8 Moderate Rehabilitation Single Room Occupancy Program have been consolidated into the Continuum of Care Program. The Act added 12 services to those eligible for funding: housing search mediation or outreach to property owners; credit repair; provision of security or utility deposits; rental assistance for a final month at a location; assistance with moving costs; and/or other activities that help individuals who are homeless move immediately into housing or would benefit individuals who have moved into permanent housing in the past 6 months.
- The Emergency Shelter Grant program has been modified and renamed the Emergency Solutions Grants (ESG) Program. The ESG Program is meant to fund not only traditional shelter and outreach activities, but also more prevention, rapid rehousing, and emergency shelter activities. Family support services for youth who are homeless, victim services, and mental health services now appear on the list of eligible services that shelters or street outreach teams can provide. Homelessness prevention activities are also expanded to include prevention and rehousing activities—such as short- or medium-term housing assistance, housing relocation or stabilization services, housing searches, mediation or outreach to property owners, legal services, credit repair, security or utility deposits, utility payments, and assistance with moving costs—for people who are homeless or at risk of homelessness.

In addition, the HEARTH Act creates the "Collaborative Applicant." This allows a single entity to submit one application for McKinney-Vento funds for all agencies in the community. Each geographic area has its own Collaborative Applicant, which is not necessarily a legal entity.

Changes in funding are likely to be made by future State and Federal legislation. Requirements, eligibility, levels of funding, and types of favored programs can change, as can the community agencies with whom you collaborate to provide services. A skillful administrator is proactive, anticipating modifications in policies and opportunities covered by the new laws.

Chapter 2 of this section introduces you to the types of policies and procedures that behavioral health agencies have found helpful in working with clients who are homeless or at risk of homelessness. The intent is to provide administrators with a starting point for handling issues of safety, transportation, medical emergencies, and the like, along with procedures for tracking your staff's contacts and actions with clients.

Part 2, Chapter 2

IN THIS CHAPTER

- Introduction
- Organizational Approaches to Programming for Homelessness Services
- Sample Policies and Procedures
- Sample Forms

Introduction

This chapter provides program descriptions and sample policies, procedures, and forms that support development of programming to meet the needs of people who are homeless. All documents are meant to serve as starting points; you must adapt them to suit the philosophy and procedures of your organization.

Our thanks to Deborah Fisk, LCSW, Director, Connecticut Mental Health Center Outreach and Engagement Project in New Haven, CT, and Douglas J. Warn, LCSW, Director, Project Renewal Chemical Dependence Outpatient Clinic in New York, NY, for providing some of the materials in this section. Additionally, a number of programs described below offered program descriptions illustrating different approaches to programming for homelessness.

Organizational Approaches to Programming for Homelessness Services

Homelessness services may be provided by a variety of community-based organizations: mental health clinics, substance abuse treatment programs, developmental disability service agencies, organizations specifically concerned with housing and homelessness, or as part of the community's criminal justice system or social service organizations. Additionally, these programs may be part of a faith-based organization, part of a national organization (such as Volunteers of America or the Salvation Army), or an element of State or local government. Few programs at the community level attempt to meet all community housing needs. Some may focus primarily on emergency homelessness needs, others on Housing First, and still others on individuals with substance use disorders or mental illness in remission.

Following are descriptions of four programs that reflect the range of available homelessness services in various communities. Their organizational scope, target population, staff size, funding, and responses to community needs differ, yet all four have their origins in an identified community need that was addressed by program development and implementation.

Responsibility House

Responsibility House in New Orleans, LA, began in 1994 as a halfway house for people recovering from substance use disorders. The programs of Responsibility House focus on providing services to, and improving the lives of, the most underserved populations in the New Orleans area: indigent adults who have disabilities, such as substance use disorders, serious mental illness, and/or HIV/AIDS, and people who are homeless.

Contact person

Mike Martyn, Executive Director: 504-367-4426; mmartyn@rhousela.org

Programs

The Men's Residential Treatment Program offers 3 to 6 months of treatment services in a modified therapeutic community setting for people who have substance dependence. Clients begin working on the 12 Steps, connect with sponsors, and perform community service while transitioning through four phases of treatment: discovery, primary, work search, and reentry. Funding is contracted through the State with the Jefferson Parish Human Services Authority.

Housing Opportunities for Persons With AIDS (HOPWA) programming and services are available for adult men who have substance dependence and are HIV positive. Funding comes from a U.S. Department of Housing and Urban Development (HUD) HOPWA grant to the City of New Orleans; Responsibility House is a subgrantee. Following primary treatment, those interested in living in a drug- and alcohol-free, recovery-focused setting may apply for the Sober Living Program. The program is designed for adult men who have at least 2 months of demonstrated abstinence and are employed.

Responsibility House also offers an Outpatient Treatment Program for men and women who have a substance use disorder and/or a co-occurring mental illness and who are at least 18 years old. Group, individual, and family counseling are offered for recovery from substance use disorders. Funding is from the U.S. Probation Service, Access to Recovery, private pay, and some insurance providers.

In 2000, Responsibility House began offering supportive housing to individuals and families who have disabilities and experience chronic homelessness. The goals of this program are to enable people who are homeless to maintain permanent independent housing, to assist clients in improving their financial independence and living skills, and to support clients in their quest for self-sufficiency.

Community collaboration

In 2011, Responsibility House was presented with an award for Outstanding Homeless Service Provider by UNITY of Greater New Orleans, the lead agency for the local Continuum of Care. Funding for the agency comes from HUD, the Jefferson Parish Community Development Block Grant, and several one-time grants from private foundations (Entergy, Orange County Foundation, and Greater New Orleans Foundation).

Center for Urban Community Services

The **Center for Urban Community Services** (CUCS) of New York, NY, provides a wide range of services to help individuals and

families who are homeless or were previously homeless (particularly those with behavioral or other disabling conditions) live full and satisfying lives in the community. In 2011, CUCS provided supportive housing services to 2,000 people and mental health services to 3,000 people; provided legal services, benefits, and/or other financial counseling to 5,500 adults and families at four sites, including one inside Rikers Island jail; helped 13,000 people gain access to housing and/or case management services, working under contract to city and State mental health authorities; and trained more than 3,000 service providers from 300 nonprofit organizations.

Contact person

Tony Hannigan, Executive Director: 212-801-3300

Programs

Clients' mental health and substance use issues are addressed in an integrated manner as appropriate to the program. Street outreach and placement programs follow a strict Housing First approach, aided by motivational interviewing to address specific aspects of mental illness or substance abuse. Transitional programs maintain the same tight focus on obtaining permanent housing but are able to offer integrated psychopharmacology using onsite psychiatric and medical treatment, along with an array of evidence-based practices, including motivational interviewing, illness management and recovery, and co-occurring disorders skills groups. Permanent supportive housing programs use these same evidence-based practices to help tenants pursue a broad range of personal goals and aspirations in addition to embedded supported employment. Medical detoxification and residential rehabilitation are handled by partnering agencies. CUCS case managers follow clients entering such programs, helping inform treatment and coordinate transition planning.

Community collaboration

CUCS is passionate about the welfare of all its clients, the quality of all its programs, and the skills and commitment of all its staff members. Recent highlights include the agency's lead support role in the Manhattan Outreach Consortium, which has reduced the Manhattan street homeless population by almost half by using an intensive Housing First model. The agency's Project for Psychiatric Outreach to the Homeless recently received an American Psychiatric Association Silver Achievement Award for providing services to thousands of people who are currently homeless and people who had previously been homeless at 54 sites across the city. Another accomplishment is CUCS's shift to a culture of evidence-based practice and continuous, data-driven quality improvement. Serious challenges remain, however. Perhaps the most important is the need to fully integrate primary medical care with mental health and substance abuse services. Even harder to solve is how to address the needs of New York City's undocumented immigrants who are homeless, given restrictions imposed by most major funders.

Open Arms Housing

Open Arms Housing, Inc. (OAH) of Washington, DC, provides permanent housing with ongoing supportive services for unaccompanied women who have lived on the streets or in shelters in Washington, DC. The organization is dedicated to providing permanent housing for vulnerable women who have previously been overlooked by current housing programs and services for the homeless. OAH owns a building in Northwest Washington, DC, that opened in 2009 to house 16 women who have experienced a range of mental health issues, substance use disorders, and medical conditions.

Contact person

Marilyn Kresky-Wolff, Executive Director: 202-525-3467

Program

The OAH model is unique in DC in that it operates under a Housing First approach, which holds that all individuals are entitled to safe and decent housing and that access to this housing should not be contingent on participation in services. Those services can come later, but housing is first. The OAH model is one of only a few similar programs across the country because:

- The OAH model rests on the premise that stable, safe housing is necessary to promote the physical, mental, and emotional well-being of all persons, particularly women with a history of chronic homelessness.
- OAH offers onsite supportive services that are tailored to each individual's needs and are designed to prevent a return to homelessness.
- The building is designed to feature efficiency units with a full set of kitchen appliances and a private bathroom, and community rooms with shared phones, TVs, computers, and space for workshops, meetings, and get-togethers.
- Additionally, the building has three wheelchair-accessible units and a unit equipped for a deaf person; units like these are scarce.

Onsite services provided by staff include:

- Outreach and engagement.
- Orientation to community living and assistance in obtaining housing subsidies.
- Financial management and help with activities of daily living.
- Supportive counseling and crisis intervention.
- Linkage to mental health treatment, alcohol and drug abuse counseling, assertive treatment teams, employment counseling, day programs, volunteer opportunities, self-help groups, medical treatment, home health care, and food and clothing resources.

Community collaboration

During the period from the founding of the organization until its opening in 2009, OAH received:

- Financial support from the DC Department of Housing and Community Development (DHCD) via a permanent loan and a grant jointly from DHCD and the DC Department of Mental Health.
- A Supportive Housing Program grant from HUD via the DC Community Partnership for the Prevention of Homelessness.
- Critical early support from private lenders (e.g., acquisition loan from the OpenDoor Housing Fund).
- Predevelopment and construction funds from Cornerstone, Inc., construction loans from Local Initiatives Support Corporation and Enterprise Community Partners, and a capacity-building grant from the Corporation for Supportive Housing.
- Ongoing support through the DC Housing Authority's Local Rent Supplement Program.

Open Arms has served 17 tenants. Fourteen of the initial residents are still in the building. One original resident moved out after reconnecting with family, and another moved to an apartment. No Open Arms resident has returned to homelessness.

Project Renewal

Project Renewal in New York, NY, is designed to help people who are homeless empower themselves and leave the streets for a return to health, homes, and jobs. Since 1967, it has created innovative strategies to address the barri-

ers that these men and women face. Services range from outreach to permanent housing and span case management, substance abuse and mental health services, primary medical care, and vocational rehabilitation.

Contact person

Mitchell Netburn, President and CEO: 212-620-0340

Programs

One innovative program of Project Renewal is In Homes Now (IHN), a Housing First model for chronically relapsing individuals who have substance use disorders and are homeless. It is designed to meet the special needs of people who have experienced long-term homelessness and have active substance use disorders. The program leases 110 apartments in the Bronx, Manhattan, and Brooklyn for participants, and a multidisciplinary team provides intensive case management, medical and mental health services, and occupational therapy, as well as socialization and recreational activities. All services are delivered in either the program office or the client's home. Staff members receive ongoing training in motivational interviewing and trauma-informed care. The culture of the program is one of nonjudgmental acceptance, and all interactions are centered on clients' needs rather than program rules. The relationship that develops between the staff and the clients becomes a stabilizing force in the clients' lives, allowing the staff to help guide clients toward a healthier lifestyle.

Nearly all (97 percent) tenants have remained stably housed over the past year. This success has led to the inclusion of harm-reduction beds in a key New York City–New York State supportive housing agreement. IHN operates from an office in Upper Manhattan that is viewed as a key factor for success because the office models itself after a drop-in center. Tenants come for socialization, for recreation, to meet with staff, or just to relax in a supportive community environment. Another program success is the ability to work with clients with co-occurring disorders and cognitive impairments. The team's psychiatric nurse practitioners treat such clients (about 75 percent), allowing integration of treatment for mental illness with other services. Occupational therapists help clients who have never lived independently master activities of daily living.

Community collaboration

Clients in In Homes Now are linked to community hospitals, methadone programs, and outpatient clinics. About 25 percent of clients are veterans and receive services at the local VA medical center. Funding is received from HUD, the Substance Abuse and Mental Health Services Administration, and the New York City Department of Health and Mental Hygiene.

Sample Policies and Procedures

As your organization increasingly provides services to people who are homeless, the need for policies and procedures to cover staff members working off site, dealing with other community agencies and partners, and responding to situations that are new to your organization will become clear. The policies and procedures presented in this section may alert you to areas where your organization needs additional guidelines. They refer to safety outside the office (for example, the "No Heroes Policy"), safety during outreach activities, client transportation, and handling medical and psychiatric emergencies in outreach settings. A sample memorandum of understanding (MOU) is also included at the end of this chapter.

No Heroes Policy

Policy

[Name of program] recognizes the need to address the safety of clinical and case management staff persons who deliver services to clients outside of the organization setting and to provide resources to facilitate safe practice.

Procedures

- A wide range of service activities are undertaken outside the office by clinical and case management staff affiliated with the [name of program]. Community-based work with clients includes, but is not limited to:
  - Services within other organizations and agencies (e.g., Social Security, residential facilities, primary care clinics, drop-in centers).
  - Services in public settings (e.g., grocery store, coin-operated laundry facility, library).
  - Offsite groups or community outings (e.g., theater, picnics).
  - Home visits.
  - Walks with clients.
  - Street-level outreach (e.g., city green, under bridges).
  - Outreach to shelters, soup kitchens, etc.
  - Crisis intervention to known and unknown individuals.
  - Transporting clients.
  - Medicating clients in the community.
- The safety of any plan to provide service to a client in the community must be carefully assessed before undertaking the planned service. Base the number of workers and other resources needed to facilitate safety upon consideration of the following:
  - The extent to which staff members are familiar with the client, the client's environment, and other people likely to be present in that environment.
  - The extent to which staff persons are familiar with the community or particular section of the community in which the service will be provided.
  - The extent to which staff persons are aware of client, environmental, or other risk factors that might contribute to unpredictability.
  - The time of day, season, and so forth during which service is to be provided.
  - The nature of the service to be provided and the client's likely response to the service or task to be accomplished (e.g., transporting or accompanying a client to a medical or dental procedure or an appointment that may elicit distress or other unpredictable response from the client—such as a court, probation, or Department of Child and Family Services appointment).
- Routine community-based contacts with clients who are assessed to present low risk can be accomplished by an individual staff member according to the procedures outlined in this policy.
- Under no circumstances will any staff member enter any situation that is felt to be unsafe:
  - Any questions regarding the safety of an intervention or activity will be reviewed and cleared by the Director of [name of program] or his/her designee prior to undertaking the activity or intervention in question.
  - Local police will be involved in all community visits that have been assessed as having significant potential for violence.
  - When there is disagreement among the staff regarding the safety of a particular situation, the planned activity will be suspended until consultation with the Director of [name of program] or his/her designee takes place.

  - The circumstances listed below will trigger particular attention to safety concerns and will result in the abbreviation or suspension of direct clinical contact in the community, pending consultation with the Director of [name of program] or his/her designee. Such consultation will address concerns about the safety of the staff and of the client and/or others in the client's environment or network. If further intervention is indicated, develop a plan to ensure the safety of involved staff members, including consideration of the need for police escort during:
    a. Outreach to a client who is suspected of being under the influence of nonprescribed substances at the time of contact or whose environment includes other individuals who are using substances.
    b. Outreach to a client who is suspected of or known to be carrying a weapon at the time of contact or whose environment includes individuals suspected of or known to be carrying weapons.
    c. Outreach to a client who becomes volatile or threatening during contact or in a setting in which volatile or threatening behavior is observed or anticipated.
    d. Outreach to a client who has a known history of physical violence.
- All community visits for the purpose of client contact require that workers bring an activated beeper and cellular phone.
- Established sign-out procedures will be used to facilitate awareness of staff whereabouts and attention to the safety of staff persons working outside the office setting.
- Sign-out information will include:
  - Name(s) of all staff members to be involved in outreach activity.
  - Destination.
  - Time of departure.
  - Anticipated time of return.
  - License plate number of vehicle being used.
  - Cellular phone number.
  - Beeper number (if applicable).
- If, in the course of providing community outreach, the staff begins to suspect or observe that the behavior of a client is exposing a child, elderly person, or individual served by the Department of Mental Retardation to abuse or neglect—including exposure to illicit activity or to circumstances that might imminently compromise the safety of these individuals—reports must be filed with the appropriate protective services agency according to established procedures for such reporting.
- All incidents that trigger safety concerns and/or require police/ambulance intervention will be reported to the Director of [name of program] or his/her designee immediately following the incident. Also:
  - Following interventions triggering safety concerns and/or the assistance of the police or an ambulance, staff will complete the Outreach Incident Report and an emergency response form documenting the circumstances of the need for emergency services. A review will be scheduled.
  - Team- and project-based reviews will be held as quickly as possible following all such incidents to facilitate discussion of issues related to staff safety, client treatment planning, and the interface between the project and the local police, as well as other emergency personnel.

Ensuring Safety During Street and Community Outreach

Policy

Street-level and community services will be provided through an interorganizational collaboration between [name of program] and other service agencies. The following street-level and community outreach procedures will serve as addenda to those outlined in the "No Heroes Policy" and will inform the work of all outreach staff. They will be reviewed and revised yearly in collaboration with the involved network service agencies.

Procedures

These procedures will guide the work of project staff members providing clinical or case management services in outdoor public places, such as street corners, the public green, under highway bridges, and the like:

- The safety of all street outreach sites will be reviewed and approved by [name of program] leaders prior to providing outreach to those sites. Review will include the following factors:
  - Street outreach locations cannot be isolated and desolate. Staff members must always be visible to the street and be able to access other people (including the general public) for assistance in a crisis situation.
  - The time of day is relevant to the safety of any specific street outreach site.
  - Differing numbers of staff members may be required to sustain safety at any particular outreach site.
  - Safety issues known to exist in the general area of any specific outreach site may vary.
- The safety of all approved outreach sites will be reviewed quarterly and as needed so that changes in the safety of specific sites are reflected in the day-to-day list of approved outreach sites.
- Street-level outreach may be conducted from 7:00 a.m. until 8:00 p.m.
  - Between 7:00 a.m. and 4:00 p.m., conduct street-level outreach with at least two staff members.
  - Between 4:00 p.m. and 8:00 p.m., conduct street-level outreach with at least three staff members; one stays in the driver's seat of the outreach vehicle.
  - Street outreach to individuals with whom the outreach staff has little or no familiarity will be guided by the following principles:
    a. Such individuals will not be invited into an organization vehicle for purposes of engaging in an interview or for the provision of transportation.
    b. Efforts will be made to interview such individuals in community agencies or public buildings (e.g., the library, a train station) instead of on public streets.

The following procedures will guide the provision of clinical and case management services that take place inside community settings (e.g., local shelters, soup kitchens, train stations, public libraries):

- All indoor sites will be established in collaboration between the [name of program] leaders and the proposed community organization sites before using those sites for outreach. The safety of each proposed community outreach site depends upon the following factors:
  - The community organization must agree to have outreach staff members visit their site.
  - A contact person must be identified within each community organization and must be available to outreach workers when they are on site to provide support.

  - The community organization must agree to allow workers telephone access for emergencies.

The following guidelines apply to outreach and clinical/case management services provided in either outdoor locations or specified indoor community sites:

- At least one member of the outreach team will have an activated beeper and cellular phone.
- Street-level outreach activities may be conducted in [name of program] vehicles. [Name of program] staff can be granted permission to drive the vehicles through a process initiated by the Director of the [name of program]. Use of vehicles belonging to any one of the involved affiliated organizations will be guided by the policies and procedures established by that organization.
- Outreach activities will end if any outreach team member indicates serious concerns about the safety of any particular activity.

All outreach workers will receive yearly project-based training in clinical and community safety, and they will be eligible to participate in the Clinical Safety Training offered at [name of program], regardless of organization affiliation.

Client Transport Policies and Procedures

Policy

The Director of [name of program] will establish procedures to guide staff decisionmaking regarding the transport of clients to enhance both the safety of the staff members providing transportation services and the safety of the clients they transport. This policy will serve as an addendum to the "No Heroes Policy."

Procedures

- Organization vehicles may be driven only by staff persons who possess valid State drivers' licenses.
- Under no circumstances will a staff member use his/her personal vehicle to transport a client.
- Organization vehicles will be used only to carry out work-related duties. Vehicles are available primarily to facilitate the care of registered clients of [name of program]. However, it is recognized that the transport of a client's nonregistered significant others is indicated at times and that the organization's ability to provide transportation can also facilitate the process of engaging nonregistered individuals who might otherwise be reluctant to accept services. These circumstances will be viewed as exceptions and will be discussed and approved by the relevant team leader, program leader, project director, or his/her designee.
- The provision of transportation to clients and their significant others will be regarded as a service, and the staff members who transport these individuals will be expected to maintain the same professional standards of practice that guide the provision of all clinical services at [name of program]. Clients' rights to safety and confidentiality will therefore be respected and protected at all times.
- Staff persons will carry an activated cellular phone when transporting clients.
- Organization vehicles used for client transport will be equipped with the following items for emergencies (e.g., accidental injuries, inclement weather):
  - An operable flashlight
  - Snow scraper
  - Personal protection gloves
  - First-aid kit
  - List of emergency phone numbers

  - Information regarding vehicle insurance coverage
  - Reflective safety triangles
- Staff will make a general inspection of the organization vehicle before driving it to make sure that there is adequate fuel and that there are no objects within or outside the vehicle that might compromise the safety of the driver or other vehicle occupants.
- The driver of any organization vehicle will maintain responsibility for ensuring that all vehicle occupants honor relevant seatbelt laws, including laws governing the use of child safety seats when applicable.
- The number of passengers transported in an organization vehicle will not exceed the vehicle's stated capacity, and team-, program-, and project-identified staff-to-client ratios will be honored.
- Clients who are symptomatically unstable and whose behavior may be impulsive and/or unpredictable will not be transported in an organization vehicle, including clients suspected of being under the influence of any nonprescribed drug. Safety concerns that arise at any point during the course of transporting a client will result in termination of the transport.
- Clients will not be left unattended by the staff in an organization vehicle.
- Clients needing hospitalization will generally be transported via ambulance. Any exceptions will be reviewed and approved by the appropriate team leader, program leader, project director, or his/her designee and will be based on a thorough assessment of client needs and the availability of the resources necessary to facilitate safe transport. Factors that will **preclude** the transportation in a vehicle of a client needing hospitalization include, but are not limited to:
  - The presence of medical needs better addressed in an ambulance.
  - Client history of violence, impulsivity, substance use, or other factors that might contribute to unpredictability during transport.
  - The lack of at least two clinicians or case managers available to assist in the transport of the client.

Management of Psychiatric and Medical Emergencies

Policy

Procedures will be established to guide the handling of psychiatric or medical emergencies within the office or in the community that require resources beyond the scope of [name of program] services. When a medical emergency occurs, basic life support, first aid, and immediate emergency care will be given until the arrival of emergency medical service (EMS) personnel, who will provide any further emergency treatment and transport to the emergency department (ED).

Purpose

To facilitate the safety of clients served by the [name of program] and the safety of team or project staff.

Procedures

Section A: Psychiatric/medical emergencies that occur within the office will be managed as follows:

- Staff members involved in the management of a psychiatric or medical emergency will dial 911 to access emergency services or will use the panic button system available within the office. If possible, one staff member will announce a Code 3 on the overhead telephone paging system, specify whether the code is medical, and note the location of the code.
- All available clinical staff persons will respond.

- The first senior staff member on the scene will take charge of a psychiatric code. The first senior medically trained staff member on the scene will take charge of a medical code. If the code bag and first-aid kits are not present, the staff member will direct another staff member to bring this equipment to the scene. If no medical personnel are available, the first person on the scene will be in charge of the code, direct basic support and first-aid to the victim, and designate someone to bring the code bag and first-aid kit.
- A staff member should gather relevant client data to provide to EMS and the ED. When EMS arrives, care of the victim in a medical code will be handed off to them. In the event of a psychiatric code, the staff member in charge of the code will manage the code collaboratively with EMS.
- The staff member in charge of the code will gather interim assistance from other staff working in the office at the time of the emergency. If the incident is in the office, a program supervisor will also facilitate the management of other clients who may be on site at the time of an emergency. These interventions will be guided by an appreciation of the importance of protecting all clients exposed to emergencies and of the need to preserve the rights, dignity, and well-being of all involved clients.
- The clinician and supervisor managing in-house psychiatric or medical emergencies are responsible for the completion of documentation needed to facilitate transport to an ED and will facilitate continuity of care for the client by communicating relevant information to ED care providers.
- After the care of the victim has been completely assumed by EMS, staff should:
  - Inform the client's family or emergency contact persons.
  - Inform appropriate administrative staff persons.
  - Address and allay the anxiety of clients who witnessed the incident.
  - Meet to review the incident as soon as possible after it occurs.
- The involved clinician will complete an incident report and an emergency response form documenting the circumstances of the need for emergency services, and a review will be scheduled.
- A note will be entered into the medical record reflecting the circumstances of the emergency and the outcome of planned interventions.
- Following a medical code, the [position of person responsible] will direct a member of the nursing department to check the lock on the code bag. If the lock is broken, the nursing staff member will call [name, phone number] to check and replace contents.

Section B: Psychiatric or medical emergencies that occur in the community will be handled as follows:

- Staff members involved in handling a psychiatric or medical emergency in the community will use their cell phones to call the local police department directly or to call 911 to access emergency services. A call to 911 from a cell phone will access State Police, who will contact local police.
- A program supervisor will be notified of the emergency and will facilitate the deployment of additional staff resources as needed.
- A first-aid kit is kept in each vehicle to facilitate interim management of medical emergencies. No code bag is stored in vehicles.
- Documentation needed to facilitate transport to an ED will be completed by the clinician most involved in the emergency situation. The involved clinician will also give relevant client information to ED

care providers to facilitate continuity of care.
- Procedures 3 through 9 as outlined in Section A of this policy will be followed.

Sample Forms

Recordkeeping is a necessary part of engaging people who are homeless in services and tracking the course of these individuals' contacts with service organizations. When possible, records should be kept electronically and updated as new information becomes available. Sample forms presented in the following pages include:

- *Sample Memorandum of Understanding.* MOUs document tasks and roles of partnership organizations.
- *Sample Homelessness Outreach Contact Form.* A sample of the type of form that can be used to document information gathered during early encounters between a service provider and a potential client. This sample form (along with the Sample Contact Log) is intended to be used during the outreach phase of homeless rehabilitation and illustrates the kinds of information you might want to record from outreach sessions. Although this form includes information that is useful, there is no expectation that it will be completed during the first several contacts with a potential client. Information gathering with people who have substance use disorders and are homeless is ongoing.
- *Sample Contact Log.* A sample of the type of form that can be used to capture case-finding work during outreach and engagement activities.
- *Sample Case Management Discharge or Transfer Note.* A sample of the type of form that is suited to record the circumstances of discharge or transfer.
- *Sample Interagency Referral Form.* A sample of the type of form that is designed to accompany an individual who is referred to an outside agency. It provides the information the client has disclosed that is relevant to the referral.

These documents are provided as a starting point for your organization. Each must be adapted to suit the particular philosophy and procedures of your organization.

Sample Memorandum of Understanding

[Name of program]

[Address]

Dear [Name of partnering colleague]:

This letter constitutes a memorandum of understanding between the [name of partnering organization], located at [address] and the [name of program] with its main office located at [address].

This understanding is solely for the purposes of clients associated with the [name of program]'s Section 8 supportive housing program for people with psychiatric disabilities that include a serious and persistent mental illness. This program intends to provide housing services to a maximum of [number] clients who will live at [address], subject to getting all zoning and commission approvals.

The [name of partnering organization] agrees to work collaboratively with the [name of program] to provide community-based psychiatric and case management services to the [number] individuals who occupy the apartments noted above through the [name of program] based at [address], provided that the clients meet the admission criteria for the [name of program]. Every effort will be made to ensure that the [name of program] is the sole source of referral for these [number] apartments. In the rare event that individuals not referred by the [name of program] are accepted for apartments, it is the expectation that the [name of program] will refer these individuals to appropriate psychiatric and case management services, including those provided by [name of program] when appropriate.

The [name of program] will be responsible for all management, upkeep, repairs, insurance, liability, and total operation of the building and program located at [address].

Please contact me at [telephone number; email address] if you have any questions.

Sincerely,

[Your name]

Director of [name of program]

CC: [relevant others]

Sample Homelessness Outreach Contact Form

Date: _____ **Name:**_____
Last First Middle

DOB:_____ **Age:**_____**SS#:**_____

Gender: Male Female **Veteran:** Yes No Unknown

Race/Ethnicity (voluntary)**:**

American Indian or Alaskan Native
Asian or Pacific Islander
Black
Hispanic/Latino
Native Hawaiian/Other Pacific Islander
White
Other: _____
Unknown

Entitlements:

SS Disability: SSI: $_____ SSR: $_____

VA Pension: $_____ VA Service Connected: $_____ SAGA Cash: $ _____

SAGA Medical: Y N Title 19: Y N Medicare/Medicaid: Y N
A: Y N B: Y N D: Y N

Employment:

Job Title: _____ Wage: _____

Employer: _____

Education: High School Graduate: Y N GED: Y N Highest Grade: _____

College: Some Associate Bachelor's Master's

Where has the person slept the past 2 weeks? How many nights in each place?

Own apartment: # _____ Someone else's apartment: #_____ Jail or prison: # _____

Shelter: # _____ Institution (hospital, nursing home): # _____ Outdoors: # _____

Public building: # _____ Abandoned building: # _____ Other: # _____

In your opinion, is the person served homeless? Yes No

Comments:

Length of time homeless this episode:

Fewer than 2 days: ___ 2–30 days: ___ 31–90 days: ___ 91 days to 1 year: ___
More than 1 year: ___ Unknown: ___

Number of episodes homeless and length of time:_____
Brief Description**:**

Eviction History: _____
Brief Description:

Where is person staying a majority of the time?

Outdoors
Short-term shelter
Long-term shelter
Own or another's apartment, room, or house
Hotel, SRO, boarding house
Jail or correctional facility
Halfway house, residential treatment program
Institution (psych, hospital, nursing home, etc.)
Unknown
Other:_____

Medical History: Does the person describe any significant medical problems? Yes No
Brief Description:

Psychiatric History: Does the person describe any significant current psychiatric symptoms or say he or she has received a psychiatric diagnosis in the past? Yes No
Brief Description:

Who was with the person at the time of contact?

1. Person was alone
2. Person was with children
3. Person was with spouse/partner
4. Person was with spouse/partner & children
5. Person was part of nonfamily group
6. Other: _____

How was contact initiated?

1. Outreach
2. Referral by shelter
3. Referral by mental health agency or provider
4. Self-referral
5. Other_____

How responsive was the person to contact?

1. Talked briefly; did not want to talk further
2. Would talk but not interested in services
3. Interested in basic services (food, clothing)
4. Interested in referral to non-PATH program
5. Interested in outreach services
6. Other: _____

GOAL:_____

Interviewer's Name:_____ **Date:**_____

Duration of Contact: 5 min 10 min 15 min 30 min 45 min 60 min 61+ min

Sample Contact Log

Counselor Name:	Date:	__Mon __Tue __Wed __Thur __Fri					
SECTION A: SCHEDULED OUTREACH RUNS							
Client Name		# of Hours		Client Name			# of Hours
SECTION B: CASE MANAGEMENT CLIENT CONTACTS (OPTIONAL)							
Client Name	Contact Type*	Contact Location†	Amount of Time‡	Client Name	Contact Type*	Contact Location†	Amount of Time‡
SECTION C: ALL NON-CASE-MANAGEMENT CONTACTS (REQUIRED) §							
Contact Name	Contact Type*	Contact Location†	Amount of Time‡	Contact Name	Contact Type*	Contact Location†	Amount of Time‡

* L=looking for/waiting with client; WC=with client; C=collateral; CI=crisis intervention (must do a critical incident report).
† O=office; CH=client home; C=community; OA=other agency.
‡ Hours and minutes in 5-minute intervals.
§ *Instructions for Section C:* (1) Include **all** contact with non-case-managed clients. (2) Include clients whose cases are managed by another outreach and engagement staff person. (3) Put case manager's name in parentheses. (4) Do not include outreach contacts that occur during a scheduled outreach run (these go in Section A).

Sample Case Management Discharge or Transfer Note

Client Name _____SS# _____ DOB _____

Admission Date _____ Case Manager _____

Discharge Date _____ New Case Manager/Clinician _____

☐ Transfer within O&E team ☐ Transfer to other provider agency_____

☐ Discharge

Reason for Discharge

☐ Dropped out/missing ☐ Incarcerated ☐ Moved away

☐ Tx continued elsewhere ☐ Facility Concurs ☐ Deceased

☐ No referral—services not needed ☐ No referral—client refused

Housing Status

☐ Homeless ☐ Private residence w/supports

☐ Institution at Discharge ☐ 24-hr residential care

☐ Private residence w/o supports ☐ Unknown address

Comment _____

Name of Program/Facility _____

Employment Status

☐ Not in labor force (disabled) ☐ Unemployed ☐ Unknown

☐ Supported/sheltered ☐ Employed F/T ☐ Employed P/T

Summary of Services

Why/how was client referred to O&E? (include referral source):

Services Provided:

Recommendations:

_____ _____ _____ _____

Case Manager **Date** **Supervisor** **Date**

Sample Interagency Referral Form

Community-Based Clinical Services

Date of Referral:_____ Referring Person:_____ Team/ Agency:_____

Phone:_____ Client's name:_____ MPI#: _____

Address:_____ CMHC#:_____

Phone: _____ DOB: _____

SSN: _____ Marital Status: _____ # of Children (if any):_____

Race/Ethnicity: _____ Emergency Contact: _____ Relationship:_____

Phone: _____ Manages Own Finances? Yes No Conservator?_____

DSM-IV-TR Diagnoses: Axis I:
Axis II:
Axis III:

Check all social/environmental factors that make it necessary to provide this level of services:

___Social isolation
___Presence of relapse trigger(s)
___Threatening spouse/significant other
___Homelessness
___Unsafe living environment or victimization
___Critical life event (or anniversary)
___Complicating medical condition(s)
___Denial of illness
___Ineffective support system
___Previous attempts to complete treatment
___History of multiple hospitalizations/ER contacts within past 2 years
___History of multiple arrests/incarcerations within past 2 years
___Active substance abuse or dependence
___Failure to take prescribed medications
___Inadequate financial support

Describe current symptoms:

Describe current case management needs:

Nature of client's involvement in treatment (including both substance abuse and mental health treatment): Describe attempts to engage client in treatment. What has worked and what hasn't?

Nature of client's community adjustment:

1. Describe current living circumstances and composition of household (include plans for housing if client is currently homeless and/or in transition):

2. Client has history of placement in residential housing program: Yes No

3. Describe current entitlement status (adapt choices to reflect specific entitlements in your area):

___Basic Needs ___ADC ___SAGA Medical ___AD
___SAGA Cash ___SSI ___Title XIX ___SSD
___Medicare ___Other (please describe):_____

4. Describe available family/other support:

5. Describe risk management issues (history of violence toward self or others):

6. Describe nature of any past arrests/incarcerations, including current legal status (name and phone # of probation officer if applicable):

7. Describe current medical problems, including name/phone of physician and/or medical clinic if applicable:

8. Describe nature of current substance abuse:

To be completed by intake clinician: Rationale for accepting or denying referral:

Appendix A—Bibliography

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Index

A
AA (Alcoholics Anonymous), 100, 102–104, 108, 112, 137
ACT (assertive community treatment), 20, 39–40, 140, 142–148, *143,* 154, 169
Addiction Technology Transfer Center Network, 164
Administrators, information for
  behavioral health program administrators, xi, 4, 5. *See also* programming
  health service providers and administrators generally, xi, 4
Agencies providing preventive services, *9*
Alcoholics Anonymous (AA), 100, 102–104, 108, 112, 137
American Psychiatric Association, 181
Appointments, missed or late, *104*
Assertive community treatment (ACT), 20, 39–40, 140, 142–148, *143,* 154, 169
Assignments for clients between sessions, *106*

B
Base Realignment and Closure program, HUD, 175
Behavioral health, defined, xii
Behavioral health program administrators, information for, xi, 4, 5. *See also* programming
Behavioral health counselors/service providers, 17–25
  attitudinal competencies and self-assessment, 18–23
  clinical interventions, involvement in, 32–33
  CODs (co-occurring disorders), working with clients with, *107*
  community housing options and, 46–48
  competencies for working with clients who are homeless, 18–20, 54
  in critical stages of recovery model, 26, *27*
  cultural competence of, 45–46
  information for, xi, 3–5
  knowledge competencies, 18
  parole officers, preparing clients for conversations with, *71*
  preventive services and, 8–9
  rewards of working with clients who are homeless, 17–18
  self-care for, 23–25, *107*
  skill competencies, 18–19
  summarizing for clients, *69*
  vignettes as training tools for. *See* vignettes
BI (brief intervention), *35*
Boston Consortium Model of Trauma-Informed Substance Abuse Treatment for Women, 44
Bottom-up planning, 48, 157, 158–161, *158,* 175
Brief intervention (BI), *35*
Brief strategic family therapy (BSFT), *111*
Brief treatment (BT), *36*

C

Case management, 37–38, 168–169, 173
CBSG (Curriculum-Based Support Group) Program, 42, *138*
Center for Mental Health Services (CMHS), 16, *141*
Center for Substance Abuse Treatment (CSAT), 18, 24
Center for Urban Community service (CUCS), New York City, 180–181
Change model of recovery, *25,* 25–26
CHC (Community Health Center) program, 173
Children. *See* families and children
Chronic homelessness, 7, 14, *15,* 157. *See also Francis vignette, pages 72-83; Juan vignette, pages 57-72*
Clinical interventions, 32–44
  case management, 37–38, 168–169, 173
  early intervention and stabilization, 35
  EBPs (evidence-based practices), 6, *40,* 39–44
  initial screening and evaluation, 34–35
  outreach and engagement, 29–30, 33
  relapse prevention and recovery management, 39
  retention and continuity of care, 38–39
  SBIRT (screening, brief intervention, and referral to treatment), 35–36, *36, 135*
  treatment and prevention planning, 37
Clinical preventive services, 8
Clinical Supervision and Professional Development of the Substance Abuse Counselor (TIP 52), 24, 56
Clinical supervisors, information for, xi
Clinician-Based Cognitive Psychoeducational Intervention, 45
Clubhouse model of transitional employment, *43*
CMHCs (community mental health centers), 139, 140, 142, 143, 144, 145
CMHS (Center for Mental Health Services), 16, *141*
Co-occurring disorders (CODs), 7, 16, 35, 44, 50, 101, 144, 161, 176
CoC (Continuum of Care) programs, 159, 162, 175, 177
Cognitive–behavioral interventions, 39, 41
Cognitive impairment, 13, 79
Collaborative Applicants, 178
Collaborative partnerships, 162–166, *165*
Community Health Center (CHC) program, 173
Community housing services, 46–54
Community mental health centers (CMHCs), 139, 140, 142, 143, 144, 145
Community services
  agencies providing preventive services, *9*
  continuum of care through interaction with community resources, 162, *163*
  environmental factors in, 12–13
  funding, 175–178
  homelessness programs, 7
  integration of programming with community services, 166–173
  responses to homelessness, 14–16
Consensus panel recommendations on preventive services, 10
Contact log, 190, 194
Contingency management, *40,* 41
Continuity of care, maintaining, 38–39
Continuum of Care (CoC) programs, 159, 162, 175, 177
Continuum of care through interaction with community resources, 162, *163*
Coping Cat Program, *138*
Corporation for Supportive Housing (CSH), 153
Cost-effectiveness of supportive housing, *153*
Counselors. *See* behavioral health counselors
Critical time intervention (CTI), 39, 40
CSAT (Center for Substance Abuse Treatment), 18, 23
CSH (Corporation for Supportive Housing), 153
CTI (critical time intervention), 39, 40
CUCS (Center for Urban Community service), New York City, 180–181
Cultural competence, 45–46

Curriculum-Based Support Group (CBSG) Program, 42, *138*

D

Damp housing, 51, *52*
DARE To Be You (DTBY), 45
DCHV (Domiciliary Care for Homeless Veterans), 42
DESC (Downtown Emergency Service Center), 165–166
Disaster Housing Assistance Program, 175
Discharge/transfer form, 190, 195
Disruptive clients, *87*
Documentation. *See* recordkeeping
Domiciliary Care for Homeless Veterans (DCHV), 52
Downtown Emergency Service Center (DESC), 165–166
Drop-In Centers, 52
Dry housing, 51, *52*
DTBY (DARE To Be You), 45

E

Early intervention and stabilization, 35. *See also Mikki vignette, pages 129-139*
EBPs (evidence-based practices), 6, *40,* 39–44, *138*
EDs (emergency departments), 84, 85–87, 159
Education and training, 10, 13
Emergencies, management policy and procedures for, 188–190
Emergency departments (EDs), 84, 85–87, 159
Emergency shelters, 46, 50–51, *132,* 157, 177
Emergency Solutions Grants (ESG) Program, 177
Employment
  Clubhouse model of transitional employment, *43*
  education and training, 10, 13
  environmental factors in homelessness, 12–13
  incidence of homelessness and, 21–22
  income stability, importance of, 10
  in rural areas, 53-54
  stress coping mechanisms, *139*
  supportive employment, *40,* 41–42, *43*
Engagement. *See* outreach and engagement
Enhancing Motivation for Change in Substance Abuse Treatment (TIP 35), 26, 41
Environmental factors in homelessness, 12–13
Episodic homelessness, *15,* 156–157
ESG (Emergency Solutions Grants) Program, 177
Evaluation and screening, 34–36, *135*
Evidence-based practices (EBPs), 6, *40,* 39–44, *138*

F

Faith-based organizations, 179
Familias Unidas, 44
Families and children. *See also See also Mikki vignette, pages 129–139; Troy vignette, pages 100–113*
  BSFT (brief strategic family therapy), *111*
  EBPs (evidence-based practices) for children, *138*
  housing for, 9, *131, 132*
  impact of homelessness on children, *22, 138*
  military families, SAMHSA Strategic Initiative on, 6
  preventive services to reduce intergenerational risk, 44
  rates of homelessness, 21–22
  social and family support issues, 10, 13
  stress coping mechanisms, *139*
Federally Qualified Health Centers (FQHCs), 73, *81,* 173
Focus of clients, maintaining, *89, 94*
Forms, 190–197
FQHCs (Federally Qualified Health Centers), 73, *81,* 173
Francis, 56, 72–83
  counselor skills and objectives, 71
  dialog with behavioral health counselor, 72–83
  potential reactions of behavioral health counselors to, 20
  setting, 73

summary of situation, *15,* 73–74, 82–83
Funding resources, 6, 175–178

G
GBHI (Grants for the Benefit of Homeless Individuals), SAMHSA, 176
Gender-related problems and gender-specific treatment, 46, 169
Grants for the Benefit of Homeless Individuals (GBHI), SAMHSA, 176

H
Halfway houses, 50, 180
HCH (Health Care for the Homeless), 160, 170, 173
HCHV (Health Care for Homeless Veterans), 51–52
Healthcare facilities providing preventive services, *9*
Health Care for Homeless Veterans (HCHV), 51–52
Health Care for the Homeless (HCH), 160, 170, 173
Health service providers and administrators generally, information for, xi, 4
HEARTH (Homeless Emergency Assistance and Rapid Transition to Housing) Act of 2009, 11, 177–178
HHS (U.S. Department of Health and Human Services), 161, 166, 170
HIV/AIDS, 13, 34, 42, 44, 180
Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, 11, 177–178
Homelessness
  behavioral health services and, 17–25. *See also* behavioral health counselors/service providers
  characteristics of persons who are homeless, 6–7, 11–12
  chronic and multiple incidences of homelessness, 7
  clinical interventions, 32–44. *See also* clinical interventions
  community responses to, 15–17. *See also* community services
  complex and multifactoral nature of, 10
  cultural competence and, 45–46
  defining, 11–12
  environmental factors, 12–13
  individual factors, 13–14
  mental illness and, 6, 7, 12–13, 22. *See also* mental illness; serious mental illness
  myths and realities about, 21–23
  number of homeless individuals, 12
  preventive services, 8–9. *See also* preventive services
  programming for, 151–197. *See also* programming
  recovery from, 26–32. *See also* recovery
  risk of, 22
  in rural areas, 53–54
  specific client needs, addressing, 44–46
  street skills, ingenuity, and resourcefulness, 22–23
  substance abuse and, 6, 7, 22, 152. *See also* substance abuse
  types of, 14, *14–15,* 156–157
  vignettes, 55–148
  Web sites, 166
HOPWA (Housing Opportunities for Persons With AIDS) program, 175, 180
Housing
  community housing services, 46–54
  costs as environmental factor in homelessness, 12–13
  families and children, 9, *131, 132*
  for families in crisis, *131*
  as first step in treating homelessness, 21, *59, 132,* 149–151
  halfway houses, 50, 180
  importance of, 7, 9
  IOP (intensive outpatient) treatment, 114, 121
  mental disorders, persons with, 49–50, *52*
  as prevention, 9
  PSH (permanent supportive housing), 16, 47, 48, 56, *136,* 171–172

in rural areas, 53–54
Section 8 Housing, *103,* 175, 176, 191
SRO (single room occupancy), *15,* 45, 47, 84–85, 88, 95, *136,* 142, 175
for people who abuse substances, 49–53, *52*
supportive, *40,* 41, *153,* 171–172
temporary, 47
¾-way houses, 50, 171
transitional supportive, 15, 47, 51, *131, 132*
for veterans, 52–53
Web sites, 166
Housing First programs, 20, *59, 132,* 153–155, 169, 179, 181, 182
Housing Opportunities for Persons With AIDS (HOPWA) program, 175, 180
HUD. *See* U.S. Department of Housing and Urban Development

I

ICM (intensive case management), 168, 171
IHN (In Homes Now), 183
Illness self-management, 39
In Homes Now (IHN), 183
Inappropriate behavior, *87, 92*
Incarceration and homelessness, 7, 14, 44, *71,* 140
Income stability, 10
Indicated prevention services, 8
Individual placement and support, VA, 40
Initial screening and evaluation, 32–35, *132*
Integrated approach to homelessness services
collaborative partnerships, 162–166, *163, 165*
community services, integration of programming with, 166–173
continuum of care through interaction with community resources, 162, *163*
primary health care services, linkages with, 173–174
SAMHSA advocacy of, 3
sample forms, 191, 194–197
Intensive care, 30–31, 168–169. *See also Roxanne vignette, pages 83-100; Troy vignette, pages 100-113*
Intensive case management (ICM), 168, 171
Intensive outpatient (IOP) treatment, 114, 121
Interagency referral form, 191, 194–197
Intergenerational problems, family services addressing, 44-45
Interorganizational partnerships, 162–166, *163, 165*
Intraorganization assessment, 164
IOP (intensive outpatient) treatment, 114, 121

J

Jobs. *See* employment
Joint sessions, *91*
Juan, 57–72
counselor skills and objectives, 58
dialog with behavioral health counselor, 58–62
setting, 57
summary of situation, 57, 72

L

Language issues, 46
Lesbian, gay, bisexual, and transgendered (LGBT) community, 46
Life-threatening conditions and situations, 6–7
Lions Quest Skills for Adolescence program, 42
Lists used to keep clients focused, *94*
Literature review, xi, 4, 5
Local agencies providing preventive services, *9*

M

Maintaining continuity of care, 38–39
Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery (TIP 48), 134
Manhattan Outreach Consortium, 181
McKinney-Vento Act, 11, 177, 178
Medicaid, 73, *81,* 154, 173
Medical issues
FQHCs (Federally Qualified Health Centers), 73, *81,* 173

life-threatening conditions in people who are homeless, incidence of, 6–7
management of psychiatric and medical emergencies, policy and procedures, 188–190
percentage of people who are homeless with, 13
refusal of services, follow-up care in cases of, *77*
specific client needs, 44
Medicare, *80,* 173
Memoranda of understanding (MOUs) or agreement (MOAs), 160, *163,* 183, 190
Mental illness. *See also Mikki vignette, pages 129-139; Roxanne vignette, pages 83-100; Sammy vignette, pages 139-148;* serious mental illness
CODs (co-occurring disorders), 13, *40,* 41, 44, *107,* 161, 176
critical stages in recovery model and, *25,* 26–29
homelessness and, 6, 7, 12–13, 23
housing as prevention, 9
housing for persons with, 49
institutional supports, loss of, 12
management of psychiatric and medical emergencies policy and procedures, 188–190
SAMHSA Strategic Initiative for preventing, 6
MI (motivational interviewing), 39, 41
Mikki, *14,* 56, 129–139
counselor skills and objectives, 130–131
dialog with behavioral health counselor, 131–138
potential reactions of behavioral health counselors to, 21
preventive services for, 38
setting, 130
summary of situation, 129–130, 139
Military families, SAMHSA Strategic Initiative on, 6
Modified therapeutic communities (MTCs), 169, 170
Modified therapeutic community for persons with co-occurring disorders, 44
Motivational interviewing (MI), 39, 41
MOUs (memoranda of understanding) or MOAs (memoranda of agreement), 160, *163,* 183, 190
MTCs (modified therapeutic communities), 169, 170
Multiple incidences of homelessness, 7

N

Narcotics Anonymous (NA), 114, 119, 125, 127, 129
National Alliance on Mental Illness (NAMI), 140, 141, *144,* 144, 145, 147
National Alliance to End Homelessness, 54, 166
National Association of Community Health Centers (NACHC), 173
National Center for Trauma-Informed Care (NCTIC), SAMHSA, *134*
National Center on Family Homelessness (NCFH), 22
National Health Care for the Homeless Council, 157, 166
National Institute on Drug Abuse (NIDA), 35
National Registry of Evidence-Based Programs and Practices (NREPP), SAMHSA, 42, *43,* 44, 45, *139,* 166
National Resource Center on Homelessness and Mental Illness, 166
National Survey of Homeless Assistance Providers and Clients, 12, 21
NCFH (National Center on Family Homelessness), 22
NCTIC (National Center for Trauma-Informed Care), SAMHSA, *134*
Network for the Improvement of Addiction Treatment, 164
NIDA (National Institute on Drug Abuse), 35
No Heroes policy and procedures, 184–185
Nongovernmental organizations, *10,* 158, 159, 160, *165*

NREPP (National Registry of Evidence-Based Programs and Practices), SAMHSA, 40, *41,* 42, 43, *134,* 161

O

OAH (Open Arms Housing, Inc.), 181–182
Ongoing rehabilitation, 31–32, 171. *See also René vignette, pages 113–129*
Open Arms Housing, Inc. (OAH), 181–182
Opening Doors, USICH, 177
Organizational approaches to programming, 179–183
Outreach and engagement, *74, 75*. *See also Francis vignette, pages 72-83; Juan vignette, pages 57-72*
  as clinical intervention, 29–30, 33
  community housing services, 51
  integration of programming with community services, 167–168
  sample forms, 190, 192–193
Overwhelmed clients, *103*
Oxford Houses, 32, 50–51, *52,* 156, 171, 172–173

P

Parole officers, preparing clients for conversations with, *71*
Partnerships, collaborative or interorganizational, 162–166, *163, 165*
PATH (Projects for Assistance in Transition from Homelessness) Program, SAMHSA, 16–17, 53, 139–140, *141,* 143, 146, 148, 176
Permanent supportive housing (PSH), 16, 47, 48, 56, *136,* 171–172
Permanent Supportive Housing Evidence-Based Practices (EBP) KIT, 172, 174
Planning treatment and prevention, 37
Policies and procedures, 183, 186–190
Posttraumatic stress disorder (PTSD), 7, 13, 83, 87
Preventive services, 8–10
  agencies providing, *10*
  case management methods, 38
  family-based, 44–45
  relapse prevention, 39, *116*
  suicide prevention, 42
  treatment and prevention planning, 37
  types of, *8*
Primary healthcare services, linkages with, 173–174
Programming, 151–197
  adaptation of existing programs, 155–162
  bottom-up, 48, 157, 158–159, *158,* 161–162
  collaborative partnerships, 162–166, *163, 165*
  community services, integration with, 166–173
  continuum of care through interaction with community resources, 162, *163*
  cost-effectiveness of, *153*
  development of, 152–153
  forms, 190–197
  funding community services, 175–178
  importance of, 151–152
  Internet resources for, 166
  organizational approaches to, 175–178
  policies and procedures, 183, 186–190
  primary healthcare services, linkages with, 173–174
  specific needs of homeless, addressing, 155–156
  top-down, 157, 159, 160–162
Progress, helping clients appreciate, *117*
Project Renewal, New York City, 182–183
Projects for Assistance in Transition from Homelessness (PATH) Program, SAMHSA, 16–17, 53, 139–140, *141,* 143, 146, 148, 176
Providers
  behavioral health service providers. *See* behavioral health counselors/service providers
  health service providers generally, information for, xi, 4
PSH (permanent supportive housing), 16, 47, 48, 56, *136,* 171–172
PTSD (posttraumatic stress disorder), 7, 13, 83, 87
Public awareness and support, 6

Public Housing Program, HUD, 176
Publicly disruptive clients, *87*

R
Recordkeeping
  MOUs or MOAs (memoranda of understanding or agreement), 160, *163,* 183, 190
  sample forms, 190–197
Recovery, 25–32
  critical stages of recovery model, 24, 25–29, *27, 28*
  defined, xii
  planned TIPs addressing, 29, 39, *116,* 171
  rehabilitation model, 25, 29–32, 167–171
  relapse prevention and recovery management, 39
  SAMHSA Strategic Initiative on, 6
  stages of change model, *25,* 25–26
  transition periods, 168, 169, 171
Referrals
  interagency referral form, 190, 196–197
  RT (referral to treatment), *36*
  transfer/discharge form, 190, 195
Refusal of services, follow-up care in cases of, *77*
Rehabilitation model of recovery, 25, 29–32, 167–171
Relapse prevention, 37–38, *116*
René, 54, 113–129
  counselor skills and objectives, 114
  dialog with behavioral health counselor, 113–129
  setting, 114
  summary of situation, 113–114, 129
Responsibility House, 180
Retention of clients in treatment, 38–39
Role-playing, *122*
Roxanne, *15,* 56, 83–100
  counselor skills and objectives, 84
  dialog with behavioral health counselor, 83–100
  potential reactions of behavioral health counselors to, 21, 83
  setting, 84
  summary of situation, 83–84, 96–97
RT (referral to treatment), *36*
Rural areas, 53–54

S
Safe housing. *See* housing
Safety policies and procedures, 183–187
SAMHSA. *See* Substance Abuse and Mental Health Services Administration
Sammy, 56, 139–148
  counselor skills and objectives, 140
  dialog with behavioral health counselor, 141–148
  setting, 136
  summary of situation, 139–140, 148
Sample forms, 190–197
Sample policies and procedures, 183, 186–190
Say It Straight program, 42
SBIRT (screening, brief intervention, and referral to treatment), 35, *36, 135*
Screening and evaluation, 34–36, *135*
Screening, brief intervention, and referral to treatment (SBIRT), 35, *36, 135*
Section 8 Housing, *103,* 175, 176, 191
Section 202 Supportive Housing for the Elderly Program, HUD, 175
Section 811 Supportive Housing for Persons with Disabilities, HUD, 175
Seeking Safety program, 44
Selective prevention services, 8
Services in Supportive Housing (SSH), SAMHSA, 175
Serious mental illness (SMI). *See also Sammy vignette, pages 139-148*
  ACT programs aimed at, 169–170
  co-occurrence with homelessness, 6
  institutional supports, loss of, 13
  PATH (Projects for Assistance in Transition from Homelessness) Program, SAMHSA, 16–17, 53, 139–140, *141,* 143, 146, 148, 176
Sexually transmitted diseases, 13
Shelters, 46, 53, *132,* 157, 177

Single room occupancy (SRO) housing, *15,* 47, 50, 84, 85, 88, *136,* 142, 175
SIs (Strategic Initiatives), SAMHSA, 6
SMI. *See* serious mental illness
Sober living houses, 50, *52*
Social and family support issues, 10, 13
Social Security Administration, 16, *137,* 150
Social Security Disability Insurance (SSDI), *141,* 145, 154
Specific client needs, addressing, 44, 155
SRO (single room occupancy) housing, *15,* 47, 50, 84, 85, 88, *136,* 142, 175
SSDI (Social Security Disability Insurance), *141,* 145, 154
SSH (Services in Supportive Housing), SAMHSA, 176
SSI (Supplemental Security Income), *141,* 154
Stabilization, 36
Stand-Down programs, 52, 177
State agencies providing preventive services, *9*
Stewart B. McKinney Homeless Assistance Amendments Act of 1990, *141,* 177
Strategic Initiatives (SIs), SAMHSA, 6
Street and community outreach safety policy and procedures, 186–187
Strengthening Families Program, 45
Stress coping mechanisms, *139*
Substance abuse. *See also Juan vignette, page 57-70; René vignette, pages 113-129; Roxanne vignette, pages 83-100; Troy vignette, pages 100-113*
  CODs (co-occurring disorders), 7, 16, 35, 44, 50, 101, 144, 161, 176
  critical stages in recovery model and, *25,* 26–29
  defined, xii
  homelessness and, 6, 7, 22, 152
  housing as prevention, 9
  housing services for people who abuse substances, 49–51, *52*
  institutional supports, loss of, 13
  SAMHSA Strategic Initiative for preventing, 6
Substance Abuse and Mental Health Services Administration (SAMHSA)
  Building your program: permanent supportive housing, 172
  as funding resource, 6, 176
  Homelessness Resource Center, 48
  NCTIC (National Center for Trauma-Informed Care), *134*
  NREPP (National Registry of Evidence-Based Programs and Practices), 40, *41,* 42, 43, *134,* 161
  PATH (Projects for Assistance in Transition from Homelessness) Program, 16–17, 53, 139–140, *141,* 143, 146, 148, 176
  PSH (permanent supportive housing), support for, 48, 172
  SBIRT (screening, brief intervention, and referral to treatment) endorsed by, 35, *135*
  Web sites, 166
Suicide prevention, 42
Summarizing for clients, *69*
Supplemental Security Income (SSI), *141,* 154
Supportive employment, *40,* 41–42, *43*
Supportive housing, *38,* 39, *149,* 169–170. *See also* permanent supportive housing; transitional supportive housing

T

Temporary housing, 47
¾-way houses, 50, 171
TIPs. *See* Treatment Improvement Protocols
Top-down planning, 157, 159, 160–162
Training and education, 10, 13
Transfer/discharge form, 190, 195
Transition periods in treatment process, 168, 171
Transitional homelessness, *14,* 16. *See also René vignette, pages 113-129*
Transitional supportive housing, 15, 47, 51, *131, 132*
Transportation of clients, policy and procedures for, 187–188
Trauma. *See also Roxanne vignette, page 83-100*
  frequency in homeless persons, 7, 13
  planned TIP addressing, 169

PTSD (posttraumatic stress disorder), 7, 13, 84, 87
SAMHSA Strategic Initiative on, 6
specific client needs, 44
Trauma-informed care, *90, 134,* 169
Trauma Recovery and Empowerment Model (TREM), 44
Treatment and prevention planning, 37
Treatment Improvement Protocols (TIPs)
Clinical Supervision and Professional Development of the Substance Abuse Counselor (TIP 52), 24, 56
cultural competence, planned TIP addressing, 46
defined, vii
Enhancing Motivation for Change in Substance Abuse Treatment (TIP 35), 26, 41
Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery (TIP 48), 134
recovery, planned TIPs addressing, 29, 39, 122, 171
trauma, planned TIP addressing, 169
TREM (Trauma Recovery and Empowerment Model), 44
Troy, 56, 100–113
counselor skills and objectives, 100–101
dialog with behavioral health counselor, 100–113
preventive services for, 38
setting, 100
summary of situation, 100, 113
12-Step programs, 32, 50, 171, 173
Types of homelessness, 14, *14–15,* 157

U

Universal prevention services, 8
U.S. Department of Health and Human Services (HHS), 161, 166, 170
U.S. Department of Housing and Urban Development (HUD)
CoC (Continuum of Care) programs, 159, 162, 175, 177
definition of homelessness, 11
as funding resource, 6, 159, 169–170, 171
Housing First and, 150
on number of individuals who are homeless, 11
PSH (permanent supportive housing), support for, 47
Section 8 Housing, *103,* 175, 176, 191
veterans, Supported Housing Program for, 52
Web site, 166
U.S. Department of Veterans Affairs (VA)
as funding resource, 6, 176–177
housing services and programs, 52
individual placement and support, 42
Web sites, 166
U.S. Interagency Council on Homelessness (USICH), 15, 177

V

VA. *See* U.S. Department of Veterans Affairs
Veterans
community housing services for, 52
HUD programs, 176
individual factors contributing to homelessness of, 13
military families, SAMHSA Strategic Initiative on, 6
Veterans Affairs Supportive Housing Program, 176
Vignettes, 55–148. *See also* Francis; Juan; Mikki; René; Roxanne; Sammy; Troy
decision trees, 56
how-to notes, 56
master clinician notes, 56
potential reactions of behavioral health counselors and, 21, 23
preventive services in, 36
purpose of, 5
skills introduced in, 55

W

Welcome Home, 140
Wellness self-management, 39
Wet housing, 51, *52*
Work. *See* employment

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TIP 37 **Substance Abuse Treatment for Persons With HIV/AIDS**—(SMA) 12-4137
Quick Guide for Clinicians MS678
KAP Keys for Clinicians KAPT37
Drugs, Alcohol, and HIV/AIDS: A Consumer Guide (SMA) 08-4127
Available in Spanish: PHD1134
Drugs, Alcohol, and HIV/AIDS: A Consumer Guide for African Americans (SMA) 07-4248

TIP 38 **Integrating Substance Abuse Treatment and Vocational Services**—(SMA) 12-4216
Quick Guide for Clinicians QGCT38
Quick Guide for Administrators QGAT38
KAP Keys for Clinicians KAPT38

TIP 39 **Substance Abuse Treatment and Family Therapy**—(SMA) 12-4219
Quick Guide for Clinicians QGCT39
Quick Guide for Administrators QGAT39

TIP 40 **Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction**—(SMA) 07-3939
Quick Guide for Physicians QGPT40
KAP Keys for Physicians KAPT40

TIP 41 **Substance Abuse Treatment: Group Therapy**—(SMA) 12-3991
Quick Guide for Clinicians (SMA) 12-4024

TIP 42 **Substance Abuse Treatment for Persons With Co-Occurring Disorders**—(SMA) 12-3992
Quick Guide for Clinicians (SMA) 07-4034
Quick Guide for Administrators (SMA) 12-4035
KAP Keys for Clinicians (SMA) 08-4036

TIP 43 **Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs**—(SMA) 12-4214
Quick Guide for Clinicians QGCT43
KAP Keys for Clinicians (SMA) 07-4108

TIP 44 **Substance Abuse Treatment for Adults in the Criminal Justice System**—(SMA) 12-4056
Quick Guide for Clinicians QGCT44
KAP Keys for Clinicians (SMA) 07-4150

TIP 45 **Detoxification and Substance Abuse Treatment**—(SMA) 12-4131
Quick Guide for Clinicians(SMA) 06-4225
Quick Guide for Administrators (SMA) 06-4226
KAP Keys for Clinicians (SMA) 06-4224

TIP 46 **Substance Abuse: Administrative Issues in Outpatient Treatment**—(SMA) 12-4157
Quick Guide for Administrators (SMA) 07-4232

TIP 47 **Substance Abuse: Clinical Issues in Outpatient Treatment**—(SMA) 12-4182
Quick Guide for Clinicians (SMA) 07-4233
KAP Keys for Clinicians (SMA) 07-4251

TIP 48 **Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery**—(SMA) 12-4353

TIP 49 **Incorporating Alcohol Pharmacotherapies Into Medical Practice**—(SMA) 12-4380
Quick Guide for Counselors (SMA) 10-4542
Quick Guide for Physicians (SMA) 10-4543
KAP Keys for Clinicians (SMA) 10-4544

TIP 50 **Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment**—(SMA) 09-4381

TIP 51 **Substance Abuse Treatment: Addressing the Specific Needs of Women**—(SMA) 09-4426

TIP 52 **Clinical Supervision and Professional Development of the Substance Abuse Counselor**—(SMA) 09-4435

TIP 53 **Addressing Viral Hepatitis in People With Substance Use Disorders**—(SMA) 11-4656

TIP 54 **Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders**—(SMA) 12-4671

TIP 55 **Behavioral Health Services for People Who Are Homeless**—(SMA) 13-4734

TIP 56 **Addressing the Specific Behavioral Health Needs of Men**—(SMA) 13-4736

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Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

A TREATMENT IMPROVEMENT PROTOCOL

Behavioral Health Services for People Who Are Homeless

A Review of the Literature*

CONTENTS

Section 1—A Review of the Literature
Section 2—Links to Select Abstracts
Section 3—General Bibliography

TIP 55

*This document is available online only (http://kap.samhsa.gov) and supports TIP 55, Behavioral Health Services for People Who Are Homeless.

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Contents

Section 1—A Review of the Literature 1-1
Introduction 1-1
Understanding the Population 1-2
Clinical Issues 1-32
Behavioral Health Interventions 1-37
Other Services 1-47
Treatment Settings 1-54
Housing 1-60
References 1-68

Section 2—Links to Select Abstracts 2-1

Section 3—General Bibliography 3-1

Section 1—A Review of the Literature

Introduction

This Treatment Improvement Protocol (TIP) is designed to assist behavioral health service providers and administrators of behavioral health programs in adapting their services, counseling techniques, and resources when working with clients who are homeless, formerly homeless, or at risk of being homeless. It presents evidence-based and promising practices and model programs for this population, which has high rates of substance use and mental disorders as well as a broad spectrum of other service needs.

This review focuses largely on literature published after 1998 and highlights the treatment and prevention of mental and substance use disorders among adults. The literature on homelessness and substance abuse treatment prior to 2001 is well reviewed in the National Health Care for the Homeless Council's *Substance Abuse Treatment: What Works for Homeless People? A Review of the Literature* (Zerger, 2002). Reviews by Martens (2001) on physical and mental disorders among people who are homeless; by Bhui, Shanahan, and Harding (2006) on the services available to treat mental illness among people who are homeless; and by Folsom and Jeste (2002) specifically on schizophrenia and homelessness are also available. The Substance Abuse and Mental Health Services Administration (SAMHSA) Homelessness Resource Center's regularly updated annotated reference list covers homelessness and behavioral health issues, relevant training materials, Webcasts, and publications (http://homelessness.samhsa.gov/).

Definitions of Homelessness

There is no single Federal definition of homelessness. However, this TIP follows most Federal programs addressing homelessness in using the definition of an individual who is homeless provided by the McKinney-Vento Act (P.L. 100-77):

> . . . an individual who lacks a fixed, regular, and adequate nighttime residence; and a person who has a nighttime residence that is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings (42 U.S.C. § 11302).

In the category of people who are homeless, three distinct clusters can be defined based on length of time homeless and number of episodes of homelessness: (1) transitionally homeless—generally homeless for a short period or a single stay of somewhat longer duration, (2) episodically homeless—frequently in and out of a state of homelessness or of various institutions that may house them temporarily, and (3) chronically homeless—regularly and for long periods of time either in the shelter system or living on the street. Among shelter users, 80 percent are estimated to be transitionally homeless, 10 percent episodically homeless, and 10 percent chronically homeless (Kuhn & Culhane, 1998).

This literature review does not cover literature on mental health and substance abuse treatment in general, but much of that literature can be applied to homeless populations. Where appropriate, this TIP refers readers to relevant TIPs and other publications available from SAMHSA.

Understanding the Population

Homelessness has been and remains a significant problem in the United States that, according to some estimates, may affect more than 2 million people per year (Burt et al., 1999). According to recent data, approximately 650,000 people were homeless on a given night in 2009 (U.S. Department of Housing and Urban Development [HUD], 2010). Ending chronic homelessness is a Federal Government priority. Treating mental and substance use disorders as well as preventing homelessness among those affected by such disorders are priorities for SAMHSA.

The reasons for homelessness among those with mental and substance use disorders are many and varied. Both substance use and mental disorders are highly correlated with homelessness, as are loss of employment, poor health, and an inability to access needed services. In addition, systemic problems such as changes in housing markets, loss of public services or institutional supports, and persisting social ills (e.g., poverty and racism) affect who becomes homeless and why (Burt, Aron, Lee, & Valente, 2001). These systemic issues are important for understanding the causes and cures for homelessness but are beyond the scope of this literature review.

Prevalence of Homelessness

Accurate data on the number of people and families who are homeless are difficult to obtain. Assessing prevalence requires an operationalized definition of homelessness, as well as a keen understanding of sampling (e.g., geographic areas, periods of time). Prevalence estimates are difficult to interpret and can be misleading without consideration of data sources (e.g., actual counts, agency records), how to avoid counting the same people twice, how to deal with missing data, when to count (e.g., because shelter use varies by season), and so forth. Even when these factors have been clarified, enumerating people who are homeless poses considerable research challenges, and estimates of prevalence are generally imprecise. Thus, one must pay careful attention to the accuracy estimates reported (when available) for the studies reviewed herein.

A historically important study of homelessness pointed to possible underestimations of rates of homelessness in the 1990 U.S. Census and in other research studies of the time (Link et al., 1994). Using telephone surveys to gather self-reports of homelessness in a nationally representative sample of currently domiciled individuals ages 18 and older, the study found that lifetime prevalence and 5-year prevalence of "literal" homelessness (e.g., sleeping in shelters, abandoned buildings, bus and train stations) were 7.4 percent and 3.1 percent, respectively. The authors translated these percentages to national estimates of 13.5 million and 5.7 million people, respectively. The error rate for these estimates is roughly plus or minus 20 percent. Concurrent research with different methodology (Culhane, Dejowski, Ibanez, Needham, & Macchia, 1994) generally confirmed Link and colleagues' (1994) estimates, suggesting that the magnitude of the homelessness problem was being underestimated in the early 1990s.

From a national policy perspective, the most important current data on homelessness prevalence are from HUD. HUD (2007) uses the definition of homelessness from the 1987 McKinney-Vento

Act (using emergency shelters or transitional housing or living on the street) to develop its prevalence estimates. HUD has conducted agency counts of individuals who were sheltered as well as "street counts" of unsheltered individuals every January since 2005 (HUD, 2010).

Street counts of individuals who are unsheltered are particularly challenging, and responsibility for data collection rests with HUD's Continuum of Care (CoC) programs—the Supportive Housing Program, the Shelter Plus Care Program, and the Section 8 Moderate Rehabilitation Single Room Occupancy Program—which were created to address the problems of homelessness in a comprehensive manner with other Federal agencies. CoC programs cover roughly 90 percent of the United States population that is homeless. The 2004 *HUD Guide to Counting Unsheltered Homeless People* describes several methods for street counts: (a) conduct counts in areas where people who are homeless are expected to congregate (e.g., service centers, parks, encampments, steam grates); (b) send teams to canvass every street in their jurisdiction; and (c) conduct interviews at nonshelter service locations such as soup kitchens. CoC programs use these and other methods adapted to their local circumstances.

HUD (2011) estimates, based on point-in-time counts, that 649,917 persons were homeless on a single given night at the end of January 2010—about 38 percent of whom were on the streets, in abandoned buildings, or in other places not meant for human habitation. These figures represent an increase of 1.1 percent from the prior year. Of these persons, 241,951 were members of families that were homeless, which represents an increase of 1.6 percent from the prior year.

The National Alliance to End Homelessness (Sermons & Witte, 2011) used data from HUD's 2009 point-in-time count to come up with a slightly higher estimate of 656,129 persons homeless on a given night, which marks a 3 percent increase over the prior year's estimate. According to this analysis of the data, at that point in time, 112,076 individuals were chronically homeless. Data also indicate that 79,652 family households and 243,156 people in those families were homeless. The number of families who were homeless increased by 4 percent over the prior year, and in some States, it increased at a much higher rate (e.g., the report estimated a 260 percent increase in families who were homeless in Mississippi). This report provides State-by-State estimates of homelessness and gives additional data on related factors such as unemployment, numbers of residential housing units, and housing costs.

According to HUD (2011) single-night-count data, 4.5 percent of people who were homeless and using shelters were veterans. HUD and the U.S. Department of Veterans Affairs (VA) produced *Veteran Homelessness: A Supplemental Report to the 2009 Annual Homeless Assessment Report to Congress*, which provides more detailed information on veterans who are homeless (HUD & VA, 2010). According to single-night counts, 75,609 veterans were homeless in January 2009; of those, 43 percent were not in shelters (i.e., were living on the streets or in a structure not intended for human habitation) (HUD & VA, 2010). Approximately 136,334 veterans spent at least one night in a shelter or transitional housing facility between October 1, 2008, and September 30, 2009, meaning that approximately 1 of every 168 veterans were homeless at some point during that period. Veterans were overrepresented among the homeless population, and rates of homelessness were particularly high for African American and Latino veterans (one in four of whom were homeless at some point during 2009). Most veterans who were homeless were living by themselves (96 percent), but 4 percent were homeless along with family members.

Prevalence of Mental Disorders Among People Who Are Homeless

Estimates of the prevalence of mental disorders among people who are homeless vary considerably, and much depends on methodological differences among studies, although there is no doubt that such disorders are significantly more common among people who are or have been homeless than among those who have always been domiciled (Greenberg & Rosenheck, 2010a) and are also more common among those who are chronically unsheltered compared with those living in shelters (Levitt, Culhane, DeGenova, O'Quinn, & Bainbridge, 2009).

Other quality data come from large national studies that included people who were formerly homeless. In analyses of data from both the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) and the National Comorbidity Study Replication (NCS-R), Greenberg and Rosenheck (2010a, b) found that people who had experienced homelessness in adulthood were significantly more likely to have every mental disorder included in those studies, with the exception of panic disorder with agoraphobia in NCS-R and agoraphobia without panic disorder in NESARC.

An earlier literature review on physical and mental disorders among those who are homeless (Martens, 2001) cited reports that found that anywhere between 25 and 90 percent of people who were homeless had a mental disorder. A review by Toro (2007) suggests that 20 to 40 percent of people who are homeless have a serious mental disorder, with 20 to 25 percent having depression and 5 to 15 percent having schizophrenia. In their introductory review, Greenberg and Rosenheck (2010a) note that estimates are that between 20 and 50 percent of people who are homeless have serious mental illness (SMI). Research reviewed by McQuistion and Gillig (2006) also indicates that between one third and one half of people who are homeless have SMI.

Although it did not assess particular mental disorders, the 2010 Annual Homeless Assessment Report (HUD, 2011) did ask shelter staff to count the number of adult shelter users with SMI during its single-night count (the method used to determine SMI varies from State to State, but it generally relies on participant self-report). In that year, 26.2 percent of people who were homeless and using shelters were reported as having SMI. As the report notes, the percentage of people who are homeless with SMI is likely higher, as many of those individuals avoid the shelter system.

Fazel, Khosla, Doll, and Geddes (2008) sought to determine the prevalence of mental disorders in persons who were homeless in seven Western countries (including the United States) by using a metaregression analysis of 29 surveys conducted between 1996 and 2007. Based on studies that evaluated psychotic disorders (28 of the total), they estimated that 12.7 percent of individuals who were homeless had a psychotic illness, 11.4 percent had major depression (based on 19 studies), and 23.1 percent had a personality disorder (based on 14 studies). It should be cautioned, however, that differences in behavioral health services and housing found in European countries (also included in the review) may mean that rates in the United States could vary significantly from these estimates.

Other estimates come from smaller, local studies. For example, in a 2000 survey of 298 men and 98 women recruited from shelters and public places in the St. Louis, MO, area, North, Eyrich, Pollio, and Spitznagel (2004) found that 23.1 percent of men and 18.9 percent of women had

schizophrenia, 27.3 percent of men and 22.9 percent of women had bipolar disorder, 27.5 percent of men and 20 percent of women had major depression, and 26.8 percent of men and 21.5 percent of women had panic disorder.

Koegel, Burnam, and Farr (1988) compared a sample (*n*=328) of people who were homeless in the Los Angeles area—of whom 95 percent were male—with a household sample from the same area (*n*=3,055). They found that the lifetime prevalence of all mental disorders/symptoms they evaluated (i.e., schizophrenia, schizoaffective disorder, major depression, dysthymia, manic episodes, panic disorder, generalized anxiety disorder [GAD], and antisocial personality disorder [ASPD]) was significantly higher among participants who were homeless.

As noted under "Histories of Trauma," people who are homeless are more likely to have had recent and past trauma than people who are housed, and the incidence of trauma increases for those who have mental and/or substance use disorders. Consequently, rates of posttraumatic stress disorder (PTSD) are also high in this population. In their analysis of NCS-R data, Greenberg and Rosenheck (2010b) found that respondents who had experienced a week or more of homelessness since age 18 were significantly more likely than those who had always been domiciled to meet criteria for PTSD (with respective rates of 17.2 and 6.3 percent). In a sample of 487 clients who were homeless before entering a shelter-based therapeutic community for substance abuse treatment, 36 percent of the women (*n*=55) and 21 percent of the men (*n*=50) met diagnostic criteria for PTSD (Jainchill, Hawke, & Yagelka, 2000). North and Smith (1992) assessed PTSD in a nontreatment sample of 900 individuals who were homeless. They found that for men, 52 percent of those with major depression had co-occurring PTSD, as did 59 percent of those with GAD, 47 percent of those with bipolar disorder, 49 percent of those with schizophrenia, 43 percent of those with ASPD, 35 percent of those with alcohol use disorder, and 42 percent of those with a drug use disorder. For women in the study, 74 percent of those with major depression had co-occurring PTSD, as did 75 percent of those with GAD, 89 percent of those with bipolar disorder, 89 percent of those with schizophrenia, 68 percent of those with ASPD, 75 percent of those with alcohol use disorder, and 75 percent of those with a drug use disorder.

People who are homeless also appear to have a high rate of ASPD. North, Eyrich, Pollio, and Spitznagel (2004) looked at data from two different surveys delivered 10 years apart that reported high rates of ASPD among people who are homeless, noting that these surveys found that 22.8 and 25.4 percent of men in those studies met criteria for an ASPD, whereas 10.3 and 18.7 percent of women met those diagnostic criteria. In comparing clients at a mental health clinic who were homeless (*n*=166) and domiciled (*n*=117), North, Thompson, Pollio, Ricci, and Smith (1997) found that rates of schizophrenia, bipolar disorder, and somatization disorder were similar for the two groups, but that clients who were homeless were significantly more likely to have a diagnosis of ASPD. They also found that total rates of personality disorders were higher among women (but not men) who were homeless compared with those who were not homeless but still used public mental health services. Personality disorders other than ASPD were higher among men who were domiciled than among men who were homeless.

Although some have suggested that high rates of ASPD diagnoses reflect issues related to homelessness rather than the actual presence of ASPD in this population, one study of 900 individuals who were homeless in St. Louis, MO, found that symptoms usually preceded the

onset of homelessness and that rates of ASPD were not significantly affected when the ASPD symptoms thought to be confounded by homelessness were discounted (North, Smith, & Spitznagel, 1993).

An under-recognized problem among adults who are homeless may be attention-deficit/ hyperactivity disorder (ADHD), which has also been linked to elevated rates of substance use disorders among adults in some studies (Levin, Evans, & Kleber 1998; Faraone et al., 2007). Although there has not been much research on the subject, one study of 81 veterans who were homeless and had a co-occurring disorder (COD) other than a psychotic disorder found that 55 percent had ADHD, even though VA treatment providers had not suspected ADHD as a possible problem in any of those cases (Lomas & Gartside, 1997).

Prevalence of Substance Abuse Among People Who Are Homeless

The extent to which people who are homeless have substance abuse problems is also important in understanding the needs of this population. Fazel et al. (2008) evaluated literature on substance use disorders in persons who were homeless in seven Western countries and found the most common substance use disorder to be alcohol dependence (based on samples comprising only men), which they estimated to affect 38 percent (ranging from 9 to 58 percent), followed by drug dependence (in men and women), estimated to affect 24 percent (ranging from 5 to 54 percent). Rates of alcohol and drug dependence were substantially higher in the homeless population than the general population.

According to the National Survey of Health Assistance Providers and Clients (NSHAPC), 38 percent of people who were homeless during 1995 and 1996 had indicators of alcohol problems in the past month, and 26 percent had indicators of drug problems (The Urban Institute et al., 1999). Of the survey population of 4,133 individuals who were or had been homeless, 68 percent were men (46 percent of whom reported alcohol problems and 30 percent of whom reported drug abuse problems) and 32 percent were women (22 percent of whom reported alcohol problems and 20 percent of whom reported drug problems). The NSHAPC study collected data from a nationally representative sample of homelessness assistance programs and their clients who were receiving services in those 2 years. Its 76 primary sampling areas included the 28 largest metropolitan statistical areas in the United States, 24 small and medium-sized metropolitan statistical areas, and 24 rural areas. In a reanalysis of the data from the NSHAPC, Dietz (2007) found that, for people who were homeless, being younger than 50 increased the odds of a current alcohol problem by 1.4 times, being male increased the odds by 2.7 times, being a veteran increased the odds by 1.3 times, and having a current mental disorder increased the odds by 1.5 times. The same factors also increased the chances of having a drug problem, although the odds ratios varied somewhat.

According to single-night counts from 2010 (HUD, 2010), 34.7 percent of people who were homeless and residing in shelters chronically abused substances (which represented an increase from 33.9 percent the prior year and a decrease from 39 percent in 2007).

However, data based on people using homelessness assistance services might not represent the full extent of substance use disorders among people who are homeless. North, Eyrich, Pollio, and Spitznagel (2004) studied lifetime prevalence of substance use disorders, finding that 58 percent

of single (i.e., unaccompanied) women who were chronically homeless and 84 percent of men who were chronically homeless had a substance use disorder. This study used datasets on homeless populations in St. Louis, MO, collected in 1980, 1990, and 2000. Another Midwestern study recruited subjects who were homeless from food programs and shelters (Forney, Lombardo, & Toro, 2007); here, 77 percent of men (n=161) and 55 percent of women (n=57) met criteria for a substance use disorder. Velasquez, Crouch, von Sternberg, and Grosdanis (2000) found that among a sample of 100 clients of the Service of the Emergency Aid Resource Center for the Homeless project in Texas, 60 percent reported use of illicit drugs in the prior 6 months. In an analysis of NESARC data for people who had experienced an episode of homelessness since the age of 15, 74.2 percent of respondents also met criteria for a lifetime substance use disorder; only 30.5 percent of those who had always been domiciled met such criteria (Greenberg & Rosenheck, 2010a). Other studies have found rates of substance use disorders among people who are homeless consistent with these rates (e.g., Booth, Sullivan, Koegel, & Burnam, 2002; Breakey et al., 1989; Caton et al., 2005; Koegel, Sullivan, Burnam, Morton, & Wenzel, 1999; North, Eyrich, Pollio, Foster, et al., 2004; North, Eyrich, Pollio, & Spitznagel, 2004; O'Toole, Conde-Martel, et al., 2004; Robertson, Zlotnick, & Westerfelt, 1997; Salit, Kuhn, Hartz, Vu, & Mosso, 1998).

Some research also indicates that rates of substance abuse among people who are homeless increased during the 1980s and 1990s. North, Eyrich, Pollio, and Spitznagel (2004) found that in the past 20 years, alcohol use problems have increased among women who are homeless, as has drug use among both men and women who are homeless. O'Toole, Conde-Martel, et al. (2004) observed that substance use disorders among people who were homeless appeared to increase significantly between the 1980s and 1990s. They compared a meta-analysis of surveys done in the 1980s (Lehman & Cordray, 1993) with their own research on individuals who were homeless in two urban areas in 1997. The observed increase came mainly from increases in drug use disorders.

Primary substance of use

According to data from the Treatment Episode Data Set (TEDS)[1], alcohol was the primary substance of abuse for 49.2 percent of clients designated as homeless who were admitted to reporting substance abuse treatment facilities in 2008, followed by heroin and other opioids (22.4 percent), cocaine (13.6 percent), amphetamines (6.3 percent), and marijuana (6 percent) (SAMHSA, Office of Applied Studies [OAS], 2011). Compared with individuals who were housed at the time of entry into substance abuse treatment, people who were homeless were more likely to list alcohol, crack/cocaine, or heroin as their primary substance of abuse. Individuals who were homeless at the time of admission were also more likely to have had three or more prior episodes of homelessness than were those who were housed at the time. These results are similar to results reported elsewhere (Burt et al., 1999; Fazel et al., 2008).

[1] TEDS is an annual compilation of data on the demographic characteristics and substance abuse problems of people admitted to substance abuse treatment. The information comes primarily from facilities that receive some public funding. TEDS records represent admissions rather than individuals, as a person may be admitted to treatment more than once. TEDS includes a Minimum Data Set collected by all States and a Supplemental Data Set collected by some States. Living arrangement is a Supplemental Data Set item. TEDS presents national statistics; thus, the percentage of clients who are homeless would be considerably higher in some urban locales.

Other studies have shown that, in some locales, crack cocaine use is particularly common among people who are homeless. Rahav and Link (1995) interviewed 518 men identified as homeless who sought community-based treatment in New York, NY, between 1991 and 1994. Thirty-five percent of the men were mentally ill, 30 percent were chemical misusers, and 14 percent were identified as both. More than 47 percent of the men identified crack as their primary substance of use, compared with 20 percent who identified alcohol as their primary substance of use. Magura, Nwakeze, Rosenblum, and Joseph (2000) studied 119 women and 100 men in New York, NY, in soup kitchens during 1997, 41 percent of whom were homeless or marginally housed. Approximately 76 percent of the subjects reported lifetime use of crack, 33 percent reported lifetime use of heroin/opiates, and 29 percent reported heavy use (five or more drinks per day) of alcohol. Orwin, Scott, and Arieira (2005) interviewed 1,326 men and women in Chicago, IL, recruited from 12 substance abuse treatment facilities and categorized on a scale that ranged from stably housed to literally homeless. Interviews were conducted at baseline, then at 6, 24, and 36 months. Crack as a primary problem substance predicted greater homelessness at baseline and, among those not homeless at baseline, predicted greater homelessness at 6 months.

Polysubstance use and more severe substance abuse

Polysubstance use is common among people who are homeless in substance abuse treatment settings. According to 2009 TEDS admissions data, people who were homeless were more likely to enter treatment having a problem with both alcohol and drugs than were those who were domiciled (this accounted for 42.5 percent of admission who were homeless and 35.4 percent of those who were in independent living situations) (U.S. Department of Health and Human Services [HHS], SAMHSA, OAS, 2011). Also, 37.9 percent of admitted individuals who were homeless reported two primary substances of abuse (compared with 32.2 percent of those housed independently) and 21.6 percent reported three (the maximum number) primary substances (compared with 19.9 percent of those housed independently).

A study of 531 adults who were homeless (80 percent of whom were men) in Pittsburgh and Philadelphia, PA, found that the majority met the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* Version III-R (DSM-III-R), criteria for substance abuse or dependence (78 percent), 32 percent commonly abused combinations of two substances, and 23 percent abused or were dependent on three or more substances (O'Toole, Gibbon, et al., 2004).

Other data indicate that, in substance abuse treatment settings, people who are homeless, compared with those who are housed, have on average more severe substance use disorders as well as more severe co-occurring mental problems (Buchholz et al., 2010).

Prevalence of People Who Are Homeless in Behavioral Health Settings

A significant percentage of clients in substance abuse treatment are homeless. SAMHSA reports that in 2009, among those admitted to substance abuse treatment facilities with known living arrangements, 12.6 percent were designated as homeless (HHS, SAMHSA, OAS, 2011).

National data concerning admissions of people who are homeless to mental health settings do not appear to be available, but some smaller studies indicate high rates of mental health service use

among those who are homeless. For example, people who are homeless are much more frequent users of psychiatric emergency services than users of such services who are domiciled (McNiel & Binder, 2005; Pasic, Russo, & Roy-Byrne, 2005); among those with SMI, homelessness has been associated with significantly higher rates of reinstitutionalization following discharge from VA inpatient mental health settings (Irmiter, McCarthy, Barry, Soliman, & Blow, 2007).

However, among a sample of 553 people who reported mental disorders in the past year, being homeless was associated with a significantly lower likelihood of having received treatment for those problems in the past year (Small, 2010).

It should be noted that methods for determining housing status in some States are likely to undercount the number of clients who are or have recently been homeless. For instance, Tommasello, Myers, Gilis, Treherne, and Plumhoff (1999) identified coding limitations in Maryland's Substance Abuse Management Information System (SAMIS), suggesting that homelessness among that State's substance abuse treatment population is actually five and a half times greater than recognized.

Behavioral Health Problems as Risk Factors for Homelessness

Although it is difficult to assess the relative impact of behavioral health problems on an individual's chances of becoming homeless, a few studies do provide some insight into factors that may have an effect, including two that analyze data from large national studies. It should be noted that the two surveys, NESARC and NCS-R, use different instruments to assess behavioral health disorders, use different interview methods, define homelessness somewhat differently, and ask different questions (for more information on survey differences see Center for Substance Abuse Treatment [CSAT], 2007).

Greenberg and Rosenheck (2010a) analyzed NESARC data to compare rates of mental and substance use disorders among people who reported a prior episode of homelessness (since the age of 15) and those who had never been homeless. In a model that controlled for the effects of other factors associated with homelessness, they found that people who met criteria for a mood disorder at some point during their lives were 2.37 times more likely to have been homeless, those with ASPD with conduct disorder were 3.4 times more likely, those with other personality disorders were 1.87 times more likely, those who had been given a schizophrenia diagnosis (the indicator used instead of meeting criteria given in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision [DSM-IV-TR] of the American Psychiatric Association) were 2.39 times more likely, and those with a substance use disorder were 2.92 times more likely. Although other factors (e.g., male gender, certain physical health problems) were also associated with increased odds of having been homeless, the authors conclude that "the most prominent independent risk factors for past homelessness were the behavioral health disorder diagnoses" (p. 364).

In another article, Greenberg and Rosenheck (2010b) looked at NCS-R data for people who had experienced at least 1 week of homelessness since age 18. According to these data, again in a model that accounted for the effects of multiple variables, the authors found that a lifetime substance use disorder diagnosis was associated with 2.7 times the risk of experiencing homelessness as an adult, a lifetime mood disorder diagnosis with 1.58 times the risk, and a

lifetime impulse control disorder with 1.63 times the risk (no data were available on the effect of schizophrenia or personality disorders).

Although Greenberg and Rosenheck's analyses (2010a,b) suggest a strong relationship between homelessness and behavioral health disorders, their data do not indicate whether those disorders generally preceded homelessness. North, Pollio, Smith, and Spitznagel (1998) did try to determine the timing of onset of mental and substance use disorders relative to experiences of homelessness by comparing a sample of 900 people who were homeless in St. Louis, MO, with a matched group drawn from participants in the Epidemiologic Catchment Area Study from the same area. They found that for all the behavioral health diagnoses they considered (schizophrenia, major depression, mania [bipolar disorder], panic disorder, GAD, ASPD, and substance use disorders), symptoms of those disorders typically preceded the onset of homelessness. However, they did not find that an earlier onset of a disorder predicted an earlier onset of homelessness (the one exception being alcohol use disorders for men). They concluded that alcohol use disorders likely contribute to homelessness, especially for men, but that there is little evidence that other disorders do, as their findings could simply reflect the natural history of such disorders.

More recently, Johnson and Fendrich (2007) examined the chronicity of illicit drug use and homelessness among a group of 627 individuals in a household survey in Chicago. They found that, after adjusting for the age of a first experience of homelessness, age of first drug use did not have a significant relationship to recent homelessness, but the age at which an individual first became homeless was significantly associated with recent drug use. They concluded that early experiences of homelessness (and/or social and family conditions related to that homelessness) influence later drug use.

Whereas Johnson and Fendrich (2007) did not address alcohol use, Sosin and Bruni (1997) did. In their analysis of data from a 1986 survey of 442 meal program users (149 of whom were homeless) in Chicago, the authors compared people who were either homeless (28 percent with alcohol problems) or very poor but still housed (35 percent with alcohol problems), finding that those who were homeless were less likely to receive public assistance, less likely to live with another adult, more likely to have been in an out-of-home placement as a child, more likely to have military experience, and more likely to have been in a mental hospital. They reviewed four models to explain how homelessness results from the interaction of substance abuse with other factors (e.g., inadequate resources, lack of social support, disinterest in social institutions, mental illness) and found that no single model explained the complexity of these interactions. Lack of work history, lack of current employment, history of mental illness, and inability to obtain welfare benefits or other institutional support all increased vulnerability to homelessness for individuals with and without alcohol-related problems. Alcohol-related problems seemed to inhibit the use of social networks to avoid homelessness, lower the resource threshold for vulnerability to homelessness, and amplify the effect of complicating mental disorders on homelessness.

However, in a 2-year study of 255 people who were homeless (using a sample drawn from both shelters and street locations), alcohol use disorders diagnosed at the start of the study did not predict housing outcomes 2 years later, but cocaine use (assessed at baseline) was significantly

associated with worse housing outcomes up to 2 years later (North, Eyrich-Garg, Pollio, & Thirthalli, 2010).

VanGeest and Johnson (2002) investigated various models for understanding the relationship between substance abuse and homelessness. They found a strong direct link between substance abuse and limited "instrumental support" (e.g., receipt of money or shelter from family or friends) and current employment status. The authors concluded from this that substance abuse indirectly influences risk of homelessness, primarily through its impact on social bonds and current employment. Individuals who are less involved in meaningful activities—like working and raising a family—may be less able or inclined to establish and maintain the social bonds others rely on during times of residential and economic instability. These authors also found that limited education and long periods of unemployment were directly linked to increased risk of homelessness during times of residential and economic instability and that substance abuse did not influence this relationship.

Some research suggests that social and environmental traits and patterns (e.g., high unemployment, increases in housing costs) might be as significant as substance abuse—if not more so—in predicting homelessness. Johnson, Freels, Parsons, and VanGeest (1997) found that a decrease in social or economic resources appeared to be a stronger predictor of a first episode of homelessness than prior drug abuse. These findings are in accord with the perceptions of people who are homeless and abuse substances. In a study by O'Toole, Gibbon, et al. (2004) of people who were homeless (78 percent of whom had a substance use disorder), 59 percent identified alcohol and drug use as a reason for becoming homeless. This was the third most commonly endorsed response after having no job (68 percent) and having no money (74 percent). Conversely, in client surveys from a National Institute on Alcohol Abuse and Alcoholism (NIAAA) project, people who were homeless listed alcohol/drug problems most often as the cause for both their first and their most recent episodes of homelessness (Leaf et al., 1993; Stevens, Erickson, Tent, Chong, & Gianas, 1993).

Prevalence of Co-Occurring Disorders Among People Who Are Homeless

The term "co-occurring disorders" refers to the presence of both a diagnosable substance use disorder and a non–substance-related mental disorder. According to SAMHSA (2002, p. 3), people with co-occurring substance use and mental disorders are:

> individuals who have at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms), at least one disorder of each type can be diagnosed independently of the other.

Rates of CODs are particularly high among people who are homeless. For people entering substance abuse treatment, being homeless is also associated with significantly more severe mental disorder symptoms and significantly more prior hospitalizations for mental illness (Eyrich-Garg, Cacciola, Carise, Lynch, & McLellan, 2008).

Estimates of the percentage of people who are homeless and have CODs vary depending on the setting from which samples are drawn. Several studies (e.g., Bird et al., 2002; Gonzalez & Rosenheck, 2002; O'Toole, Conde-Martel, et al., 2004) have sampled individuals in the general

population, individuals who were homeless or previously homeless, and individuals with SMI who were enrolled in the Center for Mental Health Services' (CMHS's) Automated Community Connection to Economic Self-Sufficiency (ACCESS) program, in homeless services and shelters, or on the street. Rates of current CODs among these homeless populations range from about 30 to 70 percent, which is 12 to 30 times higher than rates in the general population. Among users of psychiatric emergency services, rates of co-occurring substance use disorders are significantly higher for those who are homeless; in one large study, 31.6 percent of those who were homeless compared with 23.1 percent of those who were housed had co-occurring SMI and a substance-related disorder (McNiel & Binder, 2005). This range is similar to rates found in a number of other studies (Burt et al., 2001; Dickey, Gonzalez, Latimer, & Powers, 1996; Jainchill et al., 2000; North, Eyrich, Pollio, Foster, et al., 2004; North, Eyrich, Pollio, & Spitznagel, 2004; Reardon, Burns, Preist, Sachs-Ericsson, & Lang, 2003).

Several studies have found that people with substance use disorders are more likely to have CODs if they are homeless than if they are housed. For example, in comparing women with and without homelessness who used crack cocaine, Wechsberg et al. (2003) found higher rates of co-occurring depression, anxiety, and traumatic stress symptoms in the homeless sample. Wenzel, Ebener, Koegel, and Gelberg (1996) found higher rates of CODs among clients who were homeless and in substance abuse treatment in California than among those who entered treatment while housed. People with CODs may be at greater risk of homelessness because of the severity of their symptoms, denial of their problems, refusal of treatment, and tendency to abuse multiple substances (CMHS, 2003).

Several preliminary studies have attempted to identify the specific mental disorders found among persons who are homeless and have CODs. Ball, Cobb-Richardson, Connolly, Bujosa, and O'Neall (2005) studied 52 clients who were homeless and had substance use disorders and co-occurring personality disorders. They found that rates of cluster B personality disorders (antisocial, borderline, histrionic, and narcissistic) were comparable to those seen in other treatment-seeking clients. However, both cluster A (paranoid, schizoid, and schizotypal) and C (avoidant, dependent, and obsessive-compulsive) personality disorders were more common among the homeless sample. McNamara, Schumacher, Milby, Wallace, and Usdan (2001) analyzed data from a predominantly cocaine-dependent sample of 128 people who were homeless and recruited for a treatment trial based on high levels of psychiatric distress. Overall, 64 percent had a co-existing mental disorder diagnosis, the most common types of diagnoses being mood disorders (81 percent) and anxiety disorders (56 percent). As far as specific anxiety and mood disorders were concerned, the most common were major depression (48 percent), dysthymia (17 percent), major depression with partial remission (9 percent), bipolar disorder (7 percent), PTSD (24 percent), simple phobia (17 percent), GAD (11 percent), and social phobia (10 percent) (McNamara et al., 2001).

CODs for this population, as for others, are associated with more problems and often, but not always, with worse treatment outcomes. In an evaluation of a large group of adults (n=4,415) who were homeless and had SMI and for whom follow-up data were available, Gonzalez and Rosenheck (2002) found that those with CODs had worse baseline and follow-up results on clinical and social adjustment measures. Among people who were homeless and had SMI, having a co-occurring substance use disorder was one of the most frequently cited reasons for a return to

homelessness after entering supportive housing (Lipton, Siegel, Hannigan, Samuels, & Baker, 2000) or independent housing (Goldfinger et al., 1999).

However, people with CODs who are homeless can respond as well as others to behavioral health treatments if they are able to access and engage in appropriate services. McNamara et al. (2001) found that nonpsychotic mental disorders (largely depressive and anxiety disorders) did not affect substance abuse treatment outcomes for people who were homeless, diagnosed with cocaine dependence, and participating in behavioral day treatment with abstinence-contingent housing. Gonzalez and Rosenheck (2002) found that among people who were homeless and had SMI, those with a co-occurring substance use disorder who reported extensive participation in substance abuse treatment had outcomes that were as good as or better than those who did not have a co-occurring substance use disorder (on measures including days of alcohol intoxication, symptoms of depression, subjective quality of life, and criminal justice involvement). The researchers also found that among this population, a perceived need for services correlated with greater improvements in a number of outcomes during the follow-up period. They concluded that interventions aimed at improving clients' motivation for change can be particularly useful with this population (see the "Motivation for Treatment" section).

Histories of Trauma

The lives of some people who are homeless are made more difficult by substance use and mental disorders. So too, they are often affected by histories of trauma. Traumatic experiences are defined by the DSM-IV-TR (American Psychiatric Association, 2000) as events that involve "actual or threatened death or serious injury or other threat to one's physical integrity" or observing such events happening to others (p. 463). Homelessness itself does not meet these criteria for trauma, but people who are homeless have greater risk for experiencing trauma. The psychological repercussions of trauma include PTSD and acute stress disorder. Even if trauma histories do not result in a level of symptoms that meet diagnostic criteria, they can have repercussions for treatment.

People who are homeless are more likely than others to be exposed to a range of potentially traumatic experiences (e.g., assault, rape, exposure to the elements, unintentional injury, penetrating trauma) and to have been exposed to trauma in childhood (D'Amore, Hung, Chiang, & Goldfrank, 2001; Frencher et al., 2010; Wan, Morabito, Khaw, Knudson, & Dicker, 2006; Wechsberg et al., 2003; Wenzel et al., 2004). Substance use and mental disorders are also associated with a significantly increased likelihood of sustaining various traumas (in both childhood and adulthood), compounding the problem further (Booth et al., 2002; Wan et al. 2006).

Herman, Susser, Struening, and Link (1997) gathered information on adverse childhood experiences through a national random-digit telephone interview survey of 92 household members with a history of homelessness and 395 without such a history. They found that sexual abuse in childhood was associated with a nonsignificant increase in the odds of being homeless in adulthood (odds ratio [OR] of 1.7), whereas neglect and physical abuse in childhood were associated with much higher odds of being homeless in adulthood (ORs of 12.7 and 15.8, respectively). Individuals who experienced neglect combined with either physical or sexual abuse in childhood were 26 times more likely to be homeless as adults. The odds of being

homeless in adulthood (after adjusting for demographic factors) increased for those who had both neglect and abuse histories but decreased for those who had only one or the other. More recent research with a sample of 397 adults who were homeless also found significant associations between adverse childhood experiences and substance use/abuse as well as decreased participation in the workforce (Tam, Zlotnick, & Robertson, 2003).

Reports of recent trauma from people who are homeless vary by gender. Wenzel, Koegel, and Gelberg (2000) found that women who were homeless were more likely than men to have been sexually assaulted in the past 30 days. Men were somewhat more likely to report recent physical victimization.

Homelessness, behavioral health disorders, and trauma

Research has repeatedly shown a strong association between behavioral health disorders and trauma (both recent and in childhood) (see the planned TIP, *Trauma-Informed Care in Behavioral Health Services* [SAMHSA, planned j]), which, as suggested above, is likely compounded by being homeless. For example, North and Smith (1992) found that rates of trauma exposure among people who were homeless were significantly higher if individuals had a mental disorder (including substance use disorders) and that most specific disorders they evaluated were associated with significantly higher trauma exposure levels.

A review of nine studies from around the world found that among people with SMI, being homeless is associated with a significantly greater chance of being the victim of violent crime (Maniglio, 2009). Other research has found that among people who are homeless, behavioral health disorders are associated with increased risk of being the victim of violent crime. For example, Lee and Schreck (2005) studied 2,401 people who were homeless and had participated in the National Survey of Homeless Assistance Providers and Clients in 1996. Of the respondents, 74.5 percent had self-reported alcohol and/or drug problems and 68.1 percent had one or more other mental disorders. The researchers found that having substance abuse problems or mental disorders increased the likelihood—by about 40 percent and 16 percent, respectively—that a client had experienced assault, rape, and/or theft. Wenzel et al. (2004) compared women who were homeless or living in a shelter (n=460) with women who had a low income but were receiving Section 8 benefits and were thus housed (n=438). Women who were homeless had significantly higher rates of substance use disorders and were more likely than women who were housed to have sustained physical violence (34 percent versus 13 percent), sexual abuse (8 percent versus 0.5 percent), and rape (8 percent versus 0.5 percent) in the past year.

Adverse childhood events, which include childhood abuse as well as experiences such as foster care placement, domestic violence in the family, and parental deaths, have been associated with a significantly greater incidence of homelessness among people with schizophrenia spectrum disorders (Rosenberg, Lu, Mueser, Jankowski, & Cournos, 2007) and those with severe mood disorders (Lu, Mueser, Rosenberg, & Jankowski, 2008).

In a sample of 239 men who were homeless (including men in rural as well as urban communities), childhood physical abuse was associated with a 1.72 times greater likelihood of having mental health impairment (according to the Short Form Health Survey [SF-12], version 1), childhood sexual abuse with a 1.73 times greater likelihood, physical abuse in adulthood with

a 2.03 greater likelihood, and sexual abuse in adulthood with a 2.45 times greater likelihood (Kim, Ford, Howard, & Bradford, 2010).

For people who are homeless and have a substance use disorder, rates of childhood trauma (physical or sexual abuse) are especially high. Cohen and Stahler (1998) conducted indepth ethnographic interviews with 31 out-of-treatment African American men who used crack cocaine and were homeless. Most reported childhood trauma (typically involving exposure to physical and emotional interpersonal violence) often connected to gang activity. Research on African American women who used crack cocaine and were not in treatment found that women who were homeless (n=219) were significantly more likely than those who were housed (n=464) to have suffered physical abuse (42 percent versus 25 percent) and sexual abuse (40 percent versus 27 percent) before age 18 (Wechsberg et al., 2003).

In a study of both men and women living in shelters or on the street, having a substance dependence disorder was associated with higher rates of physical and/or sexual abuse, residential instability, and out-of-home placement in childhood and adolescence (Booth et al., 2002). This study assessed 1,185 people who had spent at least 1 of the past 30 nights in a temporary shelter or a setting not designed for shelter. Compared with those who did not have substance use disorders, people who reported a lifetime history of a substance dependence disorder reported higher incidences of physical and/or sexual abuse as children than people who reported never having a substance dependence disorder (12 percent of those with a lifetime diagnosis of alcohol dependence, 20 percent of those of those with a lifetime diagnosis of drug dependence, 17 percent of those with a lifetime diagnosis of alcohol and drug dependence, and 11 percent of those who had no substance dependence disorders reported this). People with a substance dependence disorder were also more likely to report violence or abuse in their homes as children that was not necessarily directed at themselves (17 percent of those with a lifetime diagnosis of alcohol dependence, 20 percent of those with a lifetime diagnosis of drug dependence, 23 percent of those with a lifetime diagnosis of alcohol and drug dependence, and 13 percent of those who had no substance dependence disorders reported this).

Trauma rates among people who are homeless in treatment populations

People who are homeless and in treatment for behavioral health disorders report high rates of trauma. Christensen et al. (2005) examined the prevalence of lifetime trauma experiences in people who were homeless and admitted to a Jacksonville, FL, integrated behavioral health program for people with CODs. Over 1 year, 80 percent of people admitted to this program (n=78) acknowledged a history of physical and/or sexual abuse. Of this population, 100 percent of the women and 69 percent of the men experienced a life-altering traumatic event. Jainchill et al. (2000) found high abuse rates in men and women (N=487, 62 percent male) at three New York, NY, shelter-based therapeutic community (TC) programs. Among the men, 67 percent had been physically abused and 14 percent had been sexually abused. Among women, 77 percent had been physically abused and 58 percent had been sexually abused. Trauma history and psychopathology were highly correlated, especially for women. Sacks, McKendrick, and Banks (2008) found that 69 percent of their treatment sample of women with substance use disorders who were homeless (N=146) reported childhood emotional, physical, and/or sexual abuse. They found a history of childhood abuse was associated with worse substance abuse treatment outcomes.

Traumatic experiences affect treatment outcomes among people who are homeless. In a study of veterans who were homeless (310 women and 315 men), Benda (2005) found that sexual and physical abuse in childhood, during military service, or in the past 2 years were strong predictors of being readmitted to substance abuse treatment, more so among women than among men. People in this study reported childhood sexual abuse (42 percent of women, 25 percent of men), childhood physical abuse (35 percent of women, 32 percent of men), sexual abuse while in the military (41 percent of women, 2 percent of men), physical abuse while in the military (8 percent of women, 3 percent of men), sexual abuse in the past 2 years (30 percent of women, 8 percent of men), and physical abuse in the past 2 years (25 percent of women, 35 percent of men).

Information on clinical interventions to address PTSD and substance use disorders can be found in the "Trauma-Informed and Trauma-Specific Services" section and in the planned TIP, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, planned j).

Cognitive Problems

People who are homeless disproportionately have cognitive disabilities, regardless of whether they have behavioral health disorders (Backer & Howard, 2007; Spence, Stevens, & Parks, 2004). Cognitive disabilities can be compounded by or result from substance use disorders, schizophrenia, traumatic (acquired) brain injury, progressive neurological disorders, and/or developmental disabilities (Backer & Howard, 2007). According to a review of 10 studies that administered the Mini Mental State Examination and were published between 1970 and 2007, between 4 and 7 percent of people who are homeless have global cognitive deficits (Burra, Stergiopoulos, & Rourke, 2009).

In Koegel and colleagues' (1988) research (described in the "Prevalence of Mental Disorders Among People Who Are Homeless" section), 3.4 percent of those who were homeless had current cognitive impairment compared with 0.7 percent of those who were domiciled, but, as noted above, rates of all mental and substance use disorders were also significantly higher for the participants who were homeless.

Solliday-McRoy, Campbell, Melchert, Young, and Cisler (2004) evaluated cognitive functioning in 90 men who were homeless, 50 percent of whom had received treatment for mental disorders and 93 percent of whom reported substance abuse/dependence behavior (although only 7 percent had received treatment for a substance use disorder). The presence of possible cognitive impairment was detected in 80 percent of the sample. Average general intellectual functioning and reading abilities were found to be relatively low, and impairments in reading, new verbal learning, memory, attention, and concentration were high. The authors observed that the men in this study had considerable assessment and treatment needs that were not being met by most of the health and social services they were offered. Douyon et al. (1998) compared veterans who were acutely homeless (n=18), chronically homeless (n=15), and domiciled (n=20) who had diagnoses of alcohol abuse/dependence or cocaine dependence and were attending inpatient treatment for either their substance use disorder or a mental disorder. All three groups of veterans had comparable substance abuse histories and similar severity of mental illness (as determined by the Brief Psychiatric Rating Scale). Although the sample size was small, the researchers found significantly higher rates of neurological impairments (as measured by the Quantified

Neurological Scale) in those who were homeless than in those who were housed, with slightly higher rates among people who were acutely homeless.

Research on men and women who are homeless and have SMI also reveals high rates of cognitive impairment. Seidman et al. (1997) evaluated neuropsychological functioning in 116 persons who were homeless and who had serious and persistent mental illness, of whom 62 percent had a co-occurring substance use disorder during their lifetime. Comparing their test scores on various measures related to cognitive functioning with mean scores from general population samples, the researchers concluded that the scores of those with SMI who were homeless were from 1 to 1.5 standard deviations below normal mean scores.

In addition, Seidman et al. (2003) found that neuropsychological functioning improved significantly for people with SMI who had been living in shelters after they entered housing (independent living or group homes) but that the type of housing did not make a significant difference. However, their research did not include a "no housing" control group; improvements may have been attributable to other factors.

Not all research, however, has found such high levels of cognitive deficits in this population. In a study that compared a matched group of people who were homeless and seeking treatment for mental disorders (n=50) with treatment-seekers who had never been homeless (n=22), Bousman et al. (2010) found no significant differences in cognitive functioning. The samples excluded people with a psychotic spectrum disorder and those who were intoxicated or in withdrawal from substance use. The study did find a nonsignificant trend indicating greater impairments in processing speed and executive functioning for those who were homeless. However, the authors concluded that homelessness likely has little influence on high rates of cognitive impairment seen in earlier studies.

Backer and Howard (2007) noted a general lack of assessment, diagnosis, and treatment of cognitive disabilities in this population. The authors reviewed strategies that have been suggested for treating this population, such as taking more time to explain things or using pictures to demonstrate concepts. The National Health Care for the Homeless (HCH) Clinician's Network (2003) has published guidelines for treating people who are homeless who have cognitive impairments. In addition, TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT, 1998e), contains further information on the co-occurrence of cognitive disabilities and substance use disorders as well as on treating clients with both conditions.

Prevalence of Physical Health Concerns in People Who Are Homeless

People who are homeless can have a variety of acute and chronic physical ailments, and many of their healthcare needs are unmet (Baggett, O'Connell, Singer, & Rigotti, 2010). In a review of the literature, McMurray-Avila, Gelberg, and Breakey (1999) found that the most common physical illnesses for this population were respiratory tract infections, physical trauma, female genitourinary problems, hypertension, skin and ear disorders, gastrointestinal diseases, peripheral vascular disease, musculoskeletal problems, dental problems, and vision problems. They also noted that substance abuse—the most common disorder among those who are homeless—"contributes to a wide range of other health problems resulting from self-neglect and poor

hygiene, nutritional deficiencies, trauma, exposure, accidents, victimization, toxic effects of ingested substances (e.g., hepatic cirrhosis due to alcohol), and infections (e.g., bacterial endocarditis, hepatitis, and HIV/AIDS infection due to IV [intravenous] drug use)" (p. 4).

The longer a person is homeless, the more likely he or she is to report health problems and overall poor health, which suggests that being homeless may exacerbate or even cause health problems (White, Tulsky, Dawson, Zolopa, & Moss, 1997). On the other hand, physical illness may also be a precursor to homelessness for some people, and changes in physical health may affect individuals' ability to make a living or remain housed (Schanzer, Dominguez, Shrout, & Caton, 2007).

People who are homeless are also likely to receive worse quality medical care and have greater difficulty following prescribed care, and they may be less informed about preventive measures and treatment options for a range of conditions (McMurray-Avila et al., 1999). This may lead to increased risk of infectious illness as well as more severe medical conditions and worse outcomes (e.g., asthma, diabetes, sexually transmitted diseases [STDs], complicated pregnancies) (Schanzer et al., 2007; White et al., 1997). Some significant health problems among people who are homeless are addressed in the following sections.

HIV/AIDS

Research suggests that people who are homeless have high rates of HIV/AIDS infection, although reported rates vary greatly depending on the settings in which assessments are made (e.g., substance abuse treatment program, primary care office, homeless shelter), method of assessment, and geographic locale. In addition, among people with HIV/AIDS, being homeless is associated with significantly worse physical and mental health (Kidder et al., 2007).

One large seroprevalence study of people who were homeless conducted from 1989 to 1992 at 16 sites across 14 cities reported an extremely wide range in seroprevalence, from 0 to 21.1 percent, with a median of 3.3 percent (Allen et al., 1994). Rates varied by geographic location and are dated, but the study does indicate how wide the variation in HIV/AIDS rates among different locations may be.

Rosenblum, Nuttbrock, McQuistion, Magura, and Joseph (2001) found that 15 percent of a sample of 139 people who were homeless or marginally housed and were users of a mobile medical clinic in New York, NY, had HIV antibodies. Although the sample included both people who had substance use disorders and people who did not, 76 percent of participants had used cocaine in the prior month, 20 percent reported injection drug use during their lifetime, and 28 percent were considered alcohol dependent (based on a nine-item screen reflecting DSM-IV-TR [American Psychiatric Association, 2000] criteria). HIV-positive status was lower in a study conducted in San Francisco by Robertson et al. (2004), who studied 2,508 adults who were homeless or marginally housed and concluded that the overall prevalence was 10 percent.

Hospital samples demonstrate even higher HIV/AIDS rates in people who are homeless. A study of people who were homeless who used a single New York, NY, public hospital emergency department (ED) over an 8-week period (n=252) found that 35 percent were HIV positive, compared with 13 percent of a control group of people who were housed who were admitted to

the ED during the same period (*n*=88) (D'Amore et al., 2001). Although this sample did not exclusively consider people with behavioral health disorders, rates of depression, schizophrenia, alcohol use disorders, and cocaine use were high for those who were homeless.

Salit et al. (1998) evaluated hospital discharge data for 18,864 admissions of adults who were homeless who entered hospitals in New York, NY, in 1992 and 1993 and found that 17 percent of those admissions had HIV/AIDS. For 28.5 percent of the admissions, a substance use disorder was the primary reason for admission; for 23 percent, mental illness was the primary diagnosis; in 42.9 percent and 7.3 percent of other cases, substance abuse and mental illness were indicated as secondary diagnoses, respectively. In cases where the person admitted had a substance use disorder, 22 percent also had HIV/AIDS. Although the authors used data on admissions and not on unique individuals, their analysis suggested that the findings would not vary significantly if data on individuals had been available.

Among a large group of individuals in Baltimore who injected drugs (*N*=2,452), people who were homeless at some point during the 10-year study (*n*=1,144) were more likely to be HIV positive than people who were never homeless during the study (OR=1.4; Song, Safaeian, Strathdee, Vlahov, & Celentano, 2000). Smereck and Hockman (1998) performed a large national study of people who were both homeless and housed who used illicit drugs (crack cocaine or injection drugs) but were not in treatment (*n*=16,366). The percentage who were HIV positive was significantly higher for those who considered themselves homeless (19 percent) than for the study population as a whole (11 percent). Similarly, Magura et al. (2000) found that being homeless or marginally housed was associated with increased exposure to HIV/AIDS (as well as hepatitis B), independent of drug use history, in a sample of 219 individuals selected from inner-city soup kitchens.

People who are homeless and have substance use disorders are likely to engage in behaviors that place them at high risk of contracting or spreading HIV/AIDS (and other STDs). Forney et al. (2007) found that people who were homeless and had substance use disorders were significantly more likely to engage in high-risk behaviors than those who did not have substance use disorders. In addition, no relationship was found between mental disorders (e.g., mood disorders and schizophrenia) and HIV/AIDS risk behaviors among those who were homeless. People who inject drugs and are homeless or unstably housed are more than twice as likely to report "needle sharing" as those who have stable housing (Des Jarlais, Braine, & Friedmann, 2007), and other research confirms that people who inject drugs and are homeless have significantly greater HIV risk than do those who are housed (Coady et al., 2007).

A study of women who were homeless found that those with substance use disorders were more likely to engage in several HIV/AIDS risk behaviors (Kilbourne, Herndon, Andersen, Wenzel, & Gelberg, 2002; Tucker et al., 2005). Other research indicates that women who abuse substances are more likely to engage in HIV/AIDS risk behaviors if they are also homeless (Wechsberg et al., 2003; Wenzel et al., 2004).

More information on the relationship between substance use/abuse and HIV/AIDS can be found in TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT, 2000c).

Hepatitis

Hepatitis B virus (HBV) and hepatitis C virus (HCV) are particularly common among people who are homeless and abuse substances. For example, the Rosenblum et al. (2001) study described in the "HIV/AIDS" section found a 32 percent prevalence of HCV antibodies in the sample they investigated. Nyamathi et al. (2002) investigated HCV rates among women who were homeless and their intimate partners (*N*=884, some of whom were housed). They found that 22 percent tested positive for HCV. People who used injection drugs had significantly higher rates of HCV (77 percent compared with 12 percent), as did people who had lifetime histories of alcohol abuse (30 percent compared with 15 percent), cocaine use (31 percent compared with 16 percent), methamphetamine use (32 percent compared with 21 percent), and who reported having been hospitalized for a mental disorder (35 compared with 21 percent).

Klinkenberg et al. (2003) looked at rates of HBV and HCV (as well as HIV/AIDS) among adults with co-occurring SMI and substance use disorders who were homeless (*n*=114 for whom hepatitis tests were available). They found that 44 percent had either or both viruses, 18 percent tested positive for both HBV and HCV, 14 percent tested positive for HBV alone, and 11 percent tested positive for HCV alone. Severity of substance abuse (as measured by scores on the Clinical Drug Use Scale) was correlated with the likelihood of having HBV, with every 1-point increase on that scale doubling the likelihood of being HBV-positive. A diagnosis of schizophrenia was also correlated with HBV and increased the likelihood of having HBV by four times. Injection drug use, needle sharing, and a substance dependence diagnosis all significantly increased the odds of having HCV.

More information on substance abuse treatment for clients with viral hepatitis is given in TIP 53, *Addressing Viral Hepatitis in People With Substance Use Disorders* (SAMHSA, 2011a).

Other medical problems

Rates of other disorders and diseases are also high among those who are homeless. Breakey et al. (1989) randomly selected 203 adults who were homeless from Baltimore shelters, missions, and a jail, all of whom received a full physical and psychological evaluation. They found that 68 percent of men (*n*=120) and 65 percent of women (*n*=75) had oral or dental problems, with about half of all participants having missing teeth and about one third having obvious cavities. Dermatological conditions affected 58 percent of men and 56 percent of women. Of the women, 64 percent had gynecological problems; 20 percent of men and 12.5 percent of women had hypertension; 15 percent of the total sample had cardiac arrhythmias; about 25 percent of both men and women had peripheral vascular problems; 32 percent of women and 26 percent of men had arthritis; and 35 percent of women and 18 percent of men had anemia. The authors did not separate rates of medical problems according to whether the participant had a co-occurring behavioral health disorder, but, at some point during their lives, 75.4 percent of men and 38.2 percent of women met criteria for a diagnosis of a substance use disorder, 42 percent of men and 48.7 percent of women had a major mental disorder, and 46.5 percent of men and 45.3 percent of women had an Axis II disorder (only 8.8 percent of men and 20.5 percent of women did *not* have a lifetime Axis I disorder).

Similarly, Schanzer et al. (2007) followed 445 adults (mean age of 36.9 years) for 18 months after they entered the New York, NY, homeless shelter system. At entry into the study, 6 percent were diagnosed with diabetes mellitus, 17 percent with hypertension, and 17 percent with asthma. Although the researchers did not break down the percentages of participants with these diseases who had co-occurring behavioral health disorders, 53 percent did have a substance use disorder and 35 percent had major depression upon entry. The authors also compared rates of these illnesses with rates from two other studies—one sampled the general population (ages 18 to 44 years) and the other sampled people of all ages living below the poverty line. They found rates of all mentioned illnesses among those who were homeless to be higher than the general population, but comparable—and, in some cases, lower than—those living in poverty regardless of housing status.

People who are homeless are also likely to receive worse medical care, have greater difficulty following prescribed care, and be less informed about preventive measures and treatment options for a range of conditions (McMurray-Avila et al., 1999; Wagoner, 2004). This can lead to increased risk of infectious illness as well as more severe medical conditions and worse outcomes (e.g., asthma, diabetes, sexually transmitted diseases, complicated pregnancies) (Schanzer et al., 2007; White et al., 1997).

The Boston, MA, HCH program has published a manual that discusses the medical conditions that commonly affect people who are homeless and provides information on their treatment/management. It recommends that, because people who are homeless lack control over living conditions and have difficulty managing illness, they need education about their illness, which should involve all providers who work with them (Wagoner, 2004). McMurray-Avila et al. (1999) also provide recommendations for adapting medical practice to best respond to the needs of people who are homeless.

Mortality

A number of studies have found significantly higher mortality rates for adults who are homeless than for the general population in the same cities (Barrow Herman, Cordova, & Struening, 1999; Cheung & Hwang, 2004; Hibbs et al., 1994; Hwang, Orav, O'Connell, Lebow, & Brennan, 1997). Hwang (2002) found that mortality was elevated during periods of shelter use compared with periods when persons were not using shelters (when they may have been housed or potentially unsheltered) but cautioned that a direct association between homelessness and mortality was not proven.

Hibbs et al. (1994) quantified the mortality rate in Philadelphia between 1985 and 1988 as 3.5 times higher for adults who were homeless than for the general population in that city. Hwang et al. (1997) looked at deaths among 17,292 adults who were homeless in Boston from 1988 to 1993 and had contact with the HCH program. The mortality rate was comparable to that found in the Philadelphia study (1,114 per 100,000 and 1,035 per 100,000, respectively). Barrow et al. (1999) used data from the National Death Index to analyze deaths among 1,260 adults who resided in shelters in New York, NY, in 1997, concluding that the mortality rate in shelters was about 4 times higher than in the general population of the United States.

O'Connell (2005) reviewed these and a few non-American studies of mortality in the homeless population and concluded that the mortality risk for people who were homeless was three to four times higher in any given year than for the general population. According to O'Connell's (2005) review, which reanalyzed data from a number of studies, in the Boston and Philadelphia studies mentioned above, a history of alcohol use or injection drug use increased the OR of the risk of death by 1.5 and 1.6, respectively, and in the Philadelphia study, mental issues were associated with a threefold increase in mortality.

People who are homeless are also 2.5 times more likely to have a drug overdose (Seal et al., 2001), 4 times more likely to be the victim of a homicide for men between the ages of 18 and 24 (Hwang et al., 1997), and significantly more likely to contemplate or attempt suicide (Prigerson, Desai, Mares, & Rosenheck, 2003). Among women in Canada who were homeless and under the age of 45, mortality appeared to be more than 450 percent higher than in the general population of women of the same age (Cheung & Hwang, 2004).

Employment

It is commonly assumed that people who are homeless are also unemployed, but this is not always the case. Many work but are not able to hold steady employment. In 2006, the *U.S. Conference of Mayors Report* estimated that 15 percent of all people who were homeless had full- or part-time jobs—a number that has declined in recent years (U.S. Conference of Mayors, 2006). In their study, Burt et al. (2001) found that 44 percent of the people who were homeless had done some paid work in the prior 30 days. A single-day count of people who were homeless in King County, WA (which includes the city of Seattle), found that 20 percent were employed at least part time (Putnam, Shamseldin, Rumpf, Wertheimer, & Rio, 2007). Other large studies gauge full or partial employment rates at 20 to 35 percent for people who are homeless and use substances (O'Toole, Conde-Martel, et al., 2004; Wenzel et al., 1996; Wechsberg et al., 2003). A small study of men who were homeless and used crack cocaine but were not in treatment (N=31) found that 42 percent reported full-time employment in the past year (Cohen & Stahler, 1998).

Sosin and Bruni (1997) found, in a group of people attending inpatient substance abuse treatment, that lack of work history and lack of current employment—in combination with other factors (e.g., history of mental illness, inability to obtain welfare benefits or other institutional support)—made people both with and without alcohol-related problems more vulnerable to homelessness. See the "Behavioral Health Problems as Risk Factors for Homelessness" section for more information on this study.

Specific Subpopulations of People Who Are Homeless

People who are homeless are not a homogeneous group. Even though they share common needs, there are many different subpopulations. Understanding these subpopulations and their differences can help behavioral health service providers deliver services better suited to the specific needs of individual clients.

Women

Women who are homeless appear to have somewhat different behavioral health problems and treatment needs than do men who are homeless. In national data from the Urban Institute et al. (1999), women who were homeless reported less than half the rate of alcohol problems than men (22 percent versus 46 percent) and a lower rate for drug problems (20 percent versus 30 percent). However, other studies using both in-treatment and out-of-treatment samples found women who were homeless to be more likely than men who were homeless to abuse some substances, notably crack cocaine or heroin (Geissler, Bormann, Kwiatkowski, & Braucht, 1995; Royse et al., 2000).

Burt et al. (1999) found no significant gender differences in the overall incidence of mental disorders in people who were homeless (43 percent of women and 38 percent of men had current mental disorders). However, in a study comparing women and men who were homeless (women *n*=49, men *n*=274), women were more likely than men to receive psychiatric outpatient treatment and psychiatric medications but reported, on average, one fourth the number of substance abuse treatment episodes (Geissler et al., 1995).

Patterns of substance use disorders appear to be different between women who have histories of homelessness or are currently homeless and women who are housed. Reardon et al. (2003) found that alcohol use disorders were significantly more common among women in Colorado who were formerly homeless than women who were never homeless, whereas the rates of alcohol use disorders were about the same in men who were formerly homeless and men who had never been homeless. In comparing women living in shelters (*n*=460) with those of a similar socioeconomic background who were living in low-income housing (*n*=438), Wenzel et al. (2004) found that women who were homeless were approximately twice as likely to engage in binge drinking, 3 times more likely to use illicit drugs, 13 times more likely to have a substance dependence disorder, 6 times more likely to have had a manic episode, and 8 times more likely to have had a psychotic episode. Among African American women who used crack cocaine, the frequency of use was significantly greater, as were symptoms of both depression and anxiety (the latter scored with the Drug Abuse Treatment AIDS Risk instrument), in those who were homeless than in those who were domiciled (Wechsberg et al., 2003). Other studies have also found high rates of substance use and mental disorders in women who are homeless (Caton et al., 2005; North et al., 2004; Robertson et al., 1997).

In a sample of women who were homeless, those with unsheltered status (15 or more nights of the prior 30 nights on the streets) had much higher risk of physical assault and robbery, worse mental and physical health status, greater substance use, lower likelihood of obtaining medical services, and increased sexual risk behavior (Nyamathi, Leake, & Gelberg, 2000). For more information on the specific treatment needs of female clients (regardless of housing status), see TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT, 2009d).

Veterans

Many veterans are homeless in the United States, and many others believe their housing situation is precarious, according to a survey of 1,005 veterans (Fannie Mae, 2007). Persons who are chronically unsheltered are significantly more likely than those residing in shelters to be veterans (Levitt et al., 2009).

VA estimates that 70 percent of veterans who are homeless have substance abuse problems and 45 percent have mental disorders (VA, 2007). Among veterans who are homeless and perceive a relationship between their military service and their homelessness, 75 percent state that the contributing factor was a substance abuse problem that began while they were in the military (Mares & Rosenheck, 2004). Research by Sosin and Bruni (1997) found that individuals who were homeless and had alcohol-related problems were more than twice as likely to be veterans as people who were homeless and did not have alcohol problems or people who were domiciled but did have alcohol problems. According to the NSHAPC, among those who are homeless, being a veteran increases the odds of having alcohol problems by 1.3 times (Dietz, 2007).

Tessler, Rosenheck, and Gamache (2002) used data from the ACCESS program (see the description in the "Assertive Community Treatment" section) for people with SMI to compare male participants who were veterans (n=1,252) with male participants who were not (n=3,236). They found that veterans were significantly more likely than nonveterans to have symptoms of alcohol dependence.

Most studies of veterans who are homeless focus on male veterans, but female veterans are also more likely to be homeless than other women, although rates of substance abuse and mental disorder severity do not appear significantly higher for female veterans who are homeless than for other women who are homeless (Gamache, Rosenheck, & Tessler, 2003). Other data indicate that veterans who are homeless may have worse treatment outcomes compared with other individuals who are homeless. Buchholz et al. (2010) found that veterans in substance abuse treatment who were consistently homeless also had significantly less improvement in Addiction Severity Index drug composite scores over the course of a year than did those who were consistently housed.

More information on treating veterans can be found in the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (SAMHSA, planned h).

People involved with the criminal justice system

For many reasons, people who are homeless are often faced with arrest and incarceration. If they have a behavioral health disorder, they are even more likely to have been or to become involved in the criminal justice system. Roman and Travis (2004) reviewed data from multiple sources on the percentage of inmates who were homeless at the time of their arrest and expected to be homeless upon release. They concluded that "about a tenth of the population entering prison has recently been homeless, and at least the same percentage of those who leave prisons end up homeless, for at least a while. And those with histories of mental illness and drug abuse are even more likely to be homeless" (p. iv). People who are homeless and living on the streets rather than in shelters are significantly more likely to have histories of incarceration, suggesting that surveys of sheltered populations may undercount past criminal justice involvement for those who are homeless (Levitt et al., 2009).

Various studies confirm high rates of criminal justice involvement among those who are homeless. For example, Zugazaga (2004) found that 82 percent of single men (n=54), 52 percent of single women (n=54), and 33 percent of women with dependent children (n=54) living in shelters in the Central Florida area had histories of incarceration. Among clients entering

substance abuse treatment programs in urban areas in 2003 and 2004, clients who were homeless were three times more likely to report income from illegal sources than were those who were housed and had low incomes (Eyrich-Garg et al., 2008). Among people who used injection drugs, being homeless or marginally housed was also associated with a significantly higher likelihood of receiving income from illegal sources (Coady et al., 2007).

In research with a group of 1,426 individuals in San Francisco who were homeless or marginally housed (defined as residing in low-cost residential hotels), 23 percent reported that they had been in prison at some point in their lives (Kushel, Hahn, Evans, Bangsberg, & Moss, 2005). Both substance use and previous hospitalization in a psychiatric facility were associated with increased odds of also having been in prison, with psychiatric hospitalization associated with a 1.41 times greater chance of being in prison, heroin use at some during one's life with a 1.51 times greater chance, lifetime cocaine use with a 1.67 times greater chance, and lifetime methamphetamine use with a 1.33 times greater chance. In another study in San Francisco, being homeless was associated with a twofold increase in the likelihood of having been incarcerated for people with SMI (*N*=308) (White, Chafez, Collins-Bride, & Nickens, 2006).

McNiel, Binder, and Robinson (2005) evaluated records from 12,934 people who were in the San Francisco jail system in 2000 and who accounted for 18,335 episodes of incarceration during that period. They found that 18.6 percent had been homeless before at least one arrest leading to incarceration. Significantly more people who were homeless were diagnosed with a mental disorder (including substance use disorders) by psychiatric staff at the jail at their time of entry compared with those who were not homeless at the time.

Greenberg and Rosenheck (2008) determined rates of homelessness in data from a national sample of adult jail inmates (*N*=6,953). They found that 15 percent of the jail population had been homeless in the year before incarceration—anywhere from 7.5 to 11.3 times the rate of homelessness found in general population samples. Prisoners who had been homeless were significantly more likely than other inmates to have substance use disorders and/or mental disorders. Prisoners who had been homeless were also more likely to have been incarcerated for a property crime (e.g., burglary, theft) and to have been unemployed at the time of arrest.

Other research confirms that people with substance use disorders who are homeless are more likely to be involved in the criminal justice system than other people who are homeless. Bird et al. (2002) looked at 797 adults who were homeless (360 with substance use disorders) in Houston, TX, and found that a significantly higher percentage of those with substance use disorders (43 percent) than those without substance use disorders (28 percent) had contact with the criminal justice system. Similarly, O'Toole, Conde-Martel, et al. (2004) found, in their study of 531 randomly sampled adults who were homeless, that those who had drug or alcohol dependence were significantly more likely to have been arrested in the prior year (20 percent) than were those who did not have a substance dependence disorder (10 percent).

For people with SMI, homelessness also appears to increase their risk of criminal justice involvement. According to data from a Florida county jail, for inmates who had SMI (*N*=3,769), being homeless was associated with a 1.69 times increase in the chances of having a misdemeanor arrest—but the odds of having a felony arrest were actually somewhat reduced for those who were homeless (Constantine et al., 2010).

Some people cycle back and forth between chronic homelessness and temporary incarceration. Metraux and Culhane (2004) analyzed data from 48,424 people who were released from New York State prisons to New York City between 1995 and 1998—11 percent entered a homeless shelter in the 2 years after their release. People who had used shelters prior to incarceration were five times more likely to use a shelter again upon release. Metraux and Culhane (2006) also analyzed prior incarceration records for 7,022 individuals who were in public shelters in New York City on December 1, 1997. They found that 23.1 percent had been incarcerated in a New York State prison or New York City jail at some time during the previous 2 years.

Among jail and prison inmates, past-year homelessness is associated with increased rates of mental illness. Among jail inmates, 17 percent of those with a mental disorder were homeless in the past year compared with 9 percent of those without a disorder (James & Glaze, 2006). Inmates with mental disorders who were homeless in the past year accounted for 13 percent of State prison inmates; those who were homeless without a mental disorder accounted for just 6 percent. In Federal prisons, 7 percent of inmates with a mental disorder had been homeless compared with 3 percent of those without. McNiel et al. (2005) found that 8 percent of jail incarcerations of people who were homeless involved someone with SMI, and of those, 78 percent had CODs. In comparison, 6 percent of incarcerations of people who were housed involved people with SMI.

A number of diversion programs are available for people with behavioral health disorders who are homeless. Depending on locale, these include homeless court programs, drug court programs, and—for individuals with CODs—mental health court programs (CMHS, 2003; American Bar Association, 2004). Information on substance abuse treatment for people involved in drug courts and similar diversion programs, as well as those recently released from prison (regardless of housing status), can be found in TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT, 2005b). For more information on mental health courts, see Bureau of Justice Assistance (2007).

Programs for people who are chronically drunk in public, many of whom are homeless, offer treatment as an alternative to jail for those who have frequent encounters with the law over public drunkenness and related offenses (State of Washington Joint Legislative Audit and Review Committee, 1997). These programs have succeeded in some locales at reducing costs associated with criminal justice and healthcare services for this population (Dawson & Liening, 2004; Dunford et al., 2006; McDonald, 2001).

Roman and Travis (2004) discussed housing options for people returning from incarceration. In addition, Roman, McBride, and Osborne (2006) provided useful information on housing people with mental illness who have had contact with the criminal justice system, many of whom also have co-occurring substance use disorders.

Parents with dependent children

Many people who are homeless have children for whom they need to provide care. Approximately 13 percent of adults using shelters between February 1 and April 30, 2005, were members of families that included dependent children. In suburban and rural areas, this number is likely to be considerably larger (HUD, 2007). HHS's Office of Human Services Policy (Rog,

Holupka, & Patton, 2007) prepared a detailed report titled *Characteristics and Dynamics of Homeless Families With Children*, which includes a literature review and discussion of sources for data about parents who are homeless and caring for dependent children. The report also provides information on behavioral health needs for this population.

Having children to care for appears to be an asset when an adult who is homeless is looking for stable housing or trying to maintain housing so as not to return to homelessness. As the *Evaluation of Continuums of Care for Homeless People: Final Report* (Burt et al., 2002) notes:

> In many respects, the homeless assistance systems in many communities do a better job serving families than singles. More resources are targeted to preventing families from becoming homeless, entry is often streamlined to ensure rapid placement and access to relevant services, and resources are earmarked for emergency services such as motel vouchers to ensure that no child sleeps on the street. Nonetheless, it is evident that families do face unique challenges when navigating the homeless assistance system (p. 65).

Parents with children also remain in shelters and transitional housing longer, either because policies give them priority or because the needs of dependent children motivate them to not return to the street (HUD, 2007).

A study of people who were homeless and entering substance abuse treatment (N=1,326) recruited from substance abuse treatment programs appears to confirm that having dependent children improves housing-related outcomes (Orwin et al., 2005). These researchers found that having dependent children was the most persistent nontreatment factor related to obtaining stable housing and not returning to homelessness. They suggested four possible explanations:

1. Having responsibility for children provides strong motivation to obtain and remain in housing.
2. Having dependent children enables access to more housing supports and subsidies.
3. Reverse causation is in effect (e.g., regaining custodial rights can be dependent on having stable housing).
4. This variable is a surrogate for another factor (e.g., having family support) that affects housing.

For men who are homeless, being a caregiver to one's children has been associated with lower levels of some substance-related problems. In the Burt et al. (2001) analysis of data from the NSHAPC, men with dependent children had significantly lower levels of past-month alcohol-related problems than did men who were not with children (a similar but not significant difference is also seen between women with dependent children and women without dependent children). The study also found significantly less difference in substance-related problems between men and women who had dependent children than between men and women who did not. Also, data from the ACCESS program (see the description in the "Assertive Community Treatment" section) for people with SMI who were homeless (N=7,229) indicate that men who were accompanied by dependent children had significantly greater reductions in both alcohol and drug use 3 months after program entry than did women with dependent children (Cheng & Kelly, 2008).

In their literature review on mothers who were homeless and caring for dependent children, Rog et al. (2007) found that research indicated high levels of recent and childhood trauma, PTSD, and physical health problems in this population. Although there also were high rates of substance use

and mental disorders, those disorders were less common for these women than for women who were homeless and living without dependent children. According to research reviewed by Felix and Samuels (2006), mental disorders and substance abuse likely contribute only a small amount to housing instability for low-income families.

Zlotnick, Tam, and Bradley (2010) evaluated data from the NSHAPC for women who were homeless and living alone (*n*=444) and women who were homeless and living without partners but with dependent children (*n*=405). They found significantly higher rates of alcohol use disorders and mental disorders (but not drug use disorders) among the "single" women. Those women also were significantly more likely to meet criteria for chronic homelessness than were women with children (37.1 percent and 18.6 percent, respectively, were chronically homeless).

Using data from the Fragile Families and Child Wellbeing Study for 868 mothers whose income was 50 percent or more below the poverty line at an assessment 1 year after baseline, and 760 in the same circumstances at a 3-year assessment, Reingold and Fertig (2006) evaluated changes in housing status for low-income mothers. At the 1-year assessment, 140 mothers reported being homeless, as did 110 at the 3-year assessment, with only 18 participants reporting homelessness at both points in time. They found that mothers who were homeless, compared with those who were housed in the previous year, were significantly more likely to have a drug problem, to have fair or poor health, to be born in the United States, and to have been abused by their partner. An earlier analysis of data from the National Comorbidity Study of mothers with low incomes who were homeless (*n*=220) or housed (*n*=216) also found that drug use disorders were significantly more common among mothers who were homeless but alcohol use and mental disorders were not (Bassuk, Buckner, Perloff, & Bassuk, 1998).

Lam, Wechsberg, and Zule (2004) studied African American women who used crack cocaine but were not in treatment, comparing those who had dependent children living with them (*n*=257) with those whose children were not living with them (*n*=378). Those who were current caregivers were significantly less likely to be homeless (15 percent) compared with those who did not have dependent children (41 percent). Current caregivers also used crack cocaine on significantly fewer days in the month prior to the study (a mean of 15 days of use for caregivers compared with 19 for persons who were not caregivers) and reported significantly lower levels of depression, anxiety, and PTSD symptoms. However, the women whose children lived with them were significantly less likely to have had prior substance abuse treatment (60 percent) compared with those without dependent children (70 percent).

Zugazaga (2004) compared women living in shelters with dependent children (*n*=54) and without dependent children (*n*=54), and found that women not living with dependent children reported higher rates of current alcohol use (44 percent) and drug use (46 percent) than did women with dependent children (28 percent and 20 percent, respectively). Women with children were also less likely, but not significantly so, to have SMI (53.7 percent of those with children compared with 63 percent of those without) and were significantly less likely to have had a psychiatric hospitalization (13 percent and 48.1 percent, respectively). However, in this study and the Lam et al. study, women with dependent children may have under-reported substance use because of concerns about child custody.

Other research by Zima, Wells, Benjamin, and Duan (1996), conducted with 110 mothers with dependent children who were homeless, also found that these women were underserved by behavioral health service providers. In that study, 72 percent of the women had high levels of psychological distress, indicating a probable mental and/or substance use disorder, but only 15 percent received mental health treatment, and the majority of those individuals received such services through medical providers, not specialty mental health services.

Daily responsibility for one's children can significantly decrease entry into treatment. In general, people who are homeless are more likely to attend inpatient (than outpatient) substance abuse treatment programs (see the "Treatment Settings" section), which often do not allow children to remain with parents. Kertesz, Larson, et al. (2006) conducted a 2-year follow-up (median length of follow-up was 15 months) of 274 individuals who had completed a detoxification program; 61 percent of the sample had been homeless at least some of the time in the 5 years before entering the study. Those who lived with their children (regardless of homelessness) were approximately half as likely (OR=0.51) to report any treatment during follow-up or any mutual-help group involvement (OR=0.53). Those who attended treatment were significantly more likely to attend outpatient programs than inpatient/residential programs, probably because child care was provided at outpatient but not inpatient treatment facilities. Findings were similar for homeless and low-income housed groups as well as for male and female study subjects.

Older adults

Rosenheck, Bassuk, and Salomon (1999) observe that rates of older adults among the homeless population vary considerably according to the sample. Research by Hahn, Kushel, Bangsberg, Riley, and Moss (2006) suggests that the adult homeless population is growing older. Their study found that the median age of a sample of adults (N=3,534) who used homeless shelters in the San Francisco area between 1990 and 2003 increased from 37 to 46 years old. During that same period, the percentage of the sample over age 50 grew from 11 to 32 percent. This reflects national trends, as the percentage of Americans aged 65 years and older has increased steadily since the beginning of the 20th century (3.1 million in 1900 and 33.2 million in 1994) and is projected to increase even more after the year 2010 (Wan et al., 2005) as "baby boomers" enter retirement age.

Conversely, a HUD (2007) national survey showed that adults aged 62 years and older made up a smaller percentage of those who were homeless (2 percent) in 2005 than they did of the general population (15 percent). The authors speculated that this is due to older adults qualifying for public programs like Social Security, Medicare/Medicaid, and senior housing, making homelessness less likely.

A survey of older adults who were homeless in the Los Angeles area found that over two thirds were male, almost 40 percent had some education following high school, and 28 percent were veterans (Shelter Partnerships, 2008). Another survey from homeless shelters in St. Louis, MO, found that individuals who were aged 50 and older (n=89) who were homeless and marginally housed were, compared with those under 50 (n=511), significantly more likely to be male and White and to have an alcohol and/or drug use disorder (DeMallie, North, & Smith, 1997). However, in CMHS' ACCESS study (N=7,224) of people with SMI who were homeless, rates of co-occurring, current substance use disorders were lower for those 55 and older (68.8 percent

had no such disorders) compared with younger cohorts (e.g., only 41.7 percent of those ages 30–39 had no substance use disorders) (Prigerson et al., 2003).

However, other research has found comparable rates of substance use disorders among older adults who are homeless and younger people who are homeless. Garibaldi, Conde-Martel, and O'Toole (2005) found that older adults (defined as over 50 years old) who were homeless (n=74) were significantly more likely to have mental health problems than were younger people who were homeless (n=457) but did not differ significantly in terms of substance use disorders, depression, or anxiety disorders. According to data from SAMHSA's yearly TEDS survey, adults over age 45 account for 30 percent of people who are homeless and seeking substance abuse treatment compared with 19 percent of domiciled individuals seeking treatment (SAMHSA, OAS, 2006). Patterns of substance abuse among those who are homeless, however, likely vary by age (Garibaldi et al., 2005).

Mental disorder symptoms may also be more common among older adults who are homeless. In Garibaldi et al. (2005), participants over 50 were significantly more likely to report mental health problems but not significantly more likely to report depression, anxiety, or PTSD (the three most common mental disorders in the study). Older women who are homeless, according to a review of earlier research, are less likely than older men or younger women who are homeless to have substance use disorders but more likely to have SMI (Rosenheck et al., 1999).

Many older adults who are homeless are experiencing homelessness for the first time. In a multinational study by Crane et al. (2005), only 21 percent of the 122 American adults aged 50 years and older who were currently homeless reported prior homelessness. This study was not limited to those who had behavioral health disorders, but more than half the sample had a mental disorder and/or engaged in "heavy drinking," and 64 percent reported having depression or other mental disorders.

Being older can also make it more difficult to transition back into housing after being homeless for the first time. In a study by Caton et al. (2005) of 377 single adults who were homeless for the first time, older age (in this case, being over 44 years old) was the strongest predictor of a longer period of homelessness. Again, while the study was not limited to people with behavioral health disorders, more than half the sample population met criteria for a lifetime diagnosis of an Axis I disorder.

Older adults who have experienced chronic homelessness for a large portion of their adult lives also can have difficulty transitioning to a more stable living environment. Beechem (2002) found that there is a large group of elderly men who are homeless and are long-term substance users (typically with alcohol use disorders) who, from clinician observation, are unlikely to seek or participate in treatment or housing services, and who require extensive outreach efforts to change those attitudes.

As is the case with other subpopulations, older adults who are homeless (particularly those with behavioral health disorders) are victimized much more than older adults in the general population (Dietz & Wright, 2005). Older adults who are homeless are also more likely than younger ones to suffer from physical health problems. Garibaldi et al. (2005) found that older adult participants in their survey (described earlier in this section) had significantly more

hypertension (43 percent compared with 22 percent of those under age 50) and musculoskeletal disorders such as arthritis (27 percent compared with 12 percent of those under 50), but not chronic respiratory conditions.

TIP 26, *Substance Abuse Among Older Adults* (CSAT, 1998d), contains helpful information on treating older adults in general. Preliminary research (Schonfeld et al., 2000) from a cognitive–behavioral substance abuse treatment program developed by VA for older adults (ages 60 and older) that has treated a large number of persons who are homeless (more than one third of the sample) suggests that this intervention is effective in helping people who complete the program obtain and maintain abstinence.

Cultural/ethnic groups

According to HUD (2007):

> Homelessness, like poverty, disproportionately afflicts minorities. About 59 percent of the sheltered homeless population and 55 percent of the poverty population are members of minority groups, compared with only 31 percent of the total U.S. population. African Americans constitute 12 percent of the total U.S. population but 45 percent of people who are homeless (p. 30).

Data from substance abuse treatment settings also indicate that people from non-White racial/ethnic groups are overrepresented among those who are homeless. For example, according to 2009 TEDS data, 29.9 percent of treatment admissions who were classified as homeless were African American (compared with 19.6 percent of those housed with independent living arrangements), 15.8 percent were Hispanic (compared with 12.9 percent), and 2.9 percent were American Indian/Alaskan Natives (compared with 2 percent) (HHS, SAMHSA, OAS, 2011).

However, the relationship of race/ethnicity, ethnic identity, and homelessness is not well understood. Gamst et al. (2006) explored the relationship of homeless status, ethnic identity, and ethnicity on functional impairment (examined with subscales of the Behavior and Symptom Identification Scale) of Latino (n=120), African American (n=88), White (n=123), and Native American (n=24) men and women who were homeless in Pomona, CA. Of the total sample, 41 percent currently used alcohol (36 percent of Latino participants, 47 percent of African American participants, 44 percent of White participants, and 33 percent of Native American participants), and 41 percent indicated that they currently or previously used some type of amphetamine (27 percent of Latino participants, 27 percent of African American participants, 63 percent of White participants, and 48 percent of Native American participants). Latino participants tended to be younger and less likely to report being victims of assault while homeless on the streets than other participants. Nearly half of the Latino participants were first-generation immigrants. Multivariate analysis of variance results for the entire sample suggested a statistically significant relationship between ethnicity and functional impairment, indicating that White and African American participants reported significantly worse functioning than Latino and Native American participants.

Among people with SMI, being African American is also associated with a significantly greater likelihood of being homeless, although Whites with SMI are more likely to be homeless than are Latinos or Asian Americans with SMI (Folsom et al., 2005).

Race/cultural background may also affect service delivery in complex ways. For example, the types of services people receive vary somewhat according to culture/race, but it is unclear to what extent this reflects institutional biases and/or different cultural attitudes toward services. Among people with SMI who are homeless, African Americans appear to make less use of mental health services than do Whites (Horvitz-Lennon et al., 2009), and African American women with depression who are homeless are less likely than White American women with depression (recruited from the same shelters) to receive antidepressants (Sleath et al., 2006). However, among people with SMI who are homeless, Latinos appear to make more use of case management services than do Whites (Horvitz-Lennon et al., 2009). The planned TIP, *Improving Cultural Competence* (SAMHSA, planned d), has more information on behavioral health differences among people from different cultural/racial backgrounds and on the provision of culturally responsive behavioral health services.

Clinical Issues

This TIP addresses the treatment of behavioral health disorders in people who are currently homeless, have histories of homelessness, or are at risk of becoming homeless. Rates of substance use and other mental disorders are about the same for individuals who are homeless and for those who were formerly homeless; the latter group should therefore be considered vulnerable for a return to homelessness (Reardon et al., 2003). For this reason, treatment providers can conceptualize homelessness as both literal and potential (Reardon et al., 2003; Sosin & Bruni, 1997). Addressing the needs of clients who are homeless often requires enhanced outreach, screening, assessment, case management, and counseling techniques.

Outreach

Assertive community outreach identifies people who are homeless and engages them into services. The basic barriers to engagement have not changed substantially since they were identified by Breakey (1987). These are disaffiliation (an individual's social isolation or lack of social supports); distrust of authorities; disenchantment with service providers; high degree of transience or lack of stability in terms of geographic location; and multiplicity of needs, which can cause the individual to place behavioral health services at a low priority.

Providing outreach and engagement services may be cost effective for large service systems. In one study, outreach and intensive case management (ICM) services in an emergency room setting connected people who were homeless to entitlements and community services. Engaging them into community substance abuse treatment services decreased their use of emergency services by 58 percent compared with others who did not receive outreach and ICM services (Witbeck, Hornfeld, & Dalack, 2000).

An important element of outreach is building a trusting relationship with the person who is homeless; this process can sometimes take years (Falk, 2006; McQuistion, Felix, & Samuels, 2008). Outreach workers build trusting relationships through reliability, consistency, persistence, honesty, respect, and offers of tangible assistance (e.g., food, bus tokens, help accessing services) (Christensen, 2009; Falk, 2006; Sosin & Bruni, 2000; Sosin & Grossman, 2003; Tommasello et al., 1999).

People with behavioral health disorders who are homeless may also need to be educated about the services available to them or be convinced that services can be effective for them. Freund and Hawkins (2004) found that more than half of a sample of people who were homeless in the Pittsburgh, PA, area (*N*=225) believed they were not eligible for substance abuse treatment services. Of those who reported having substance abuse problems, 42 percent said that treatment services had failed them before, usually because of a lack of continuing care and residential supports.

People who are homeless are often ready to accept services other than treatment first, and they may require assistance from outreach workers and case managers to access services that would otherwise be difficult to obtain. In a study in Buffalo, NY (Acosta & Toro, 2000), people who were homeless (*N*=301) rated safety, education, transportation, medical/dental treatment, affordable housing, and job training/placement as most important.

People who are homeless sometimes avoid behavioral health services because they view them as not helpful or respectful (Sosin & Bruni, 2000). The outreach worker or counselor, to be effective, must use the trusting relationship to guide the client to accept appropriate services and move at the client's pace (Wenzel et al., 2001). Often, a relationship must be established before the subject of treatment can be broached (Christensen, 2009).

Assertive outreach, however, can be successfully used to move people with substance use disorders who are homeless into treatment. In a small (*N*=73) study of people who had a primary diagnosis of a substance use disorder and were homeless, assertive outreach was successful in motivating 41 percent of the sample to enter treatment (Fisk, Rakfeldt, & McCormack, 2006).

Motivation for Treatment

Velasquez et al. (2000) found that a majority of people who were homeless and presented for services in a drop-in center (*N*=100) acknowledged that they drank (53 percent) or used drugs (71 percent) "too much" and had high levels of psychological distress (i.e., had a mean score on the Global Severity Index in the 93rd percentile for men and 97th percentile for women). Using the transtheoretical model (Prochaska, DiClemente, & Norcross, 1992), Velasquez et al. (2000) found that 54 percent of the people who reported alcohol use in the prior 6 months were in the precontemplation stage of change and 40 percent were in the contemplation stage. Among people who reported use of drugs, 30 percent were in the precontemplation stage of change and 60 percent were in the contemplation stage. Motivation for change requires that the individual want to change (e.g., problem recognition, desire for change) and believe that change is possible (e.g., be able to change, have access to treatment and other needed services and resources).

As noted in the prior section, for people with behavioral health disorders who are homeless, shifting motivation for behavioral health services can take time, and mental health workers may need to focus first on helping potential clients meet more immediate, instrumental needs. If appropriate services are not available, the worker or case manager should advocate in the community for services that better respond to the client's needs (McQuistion et al., 2008). Other factors that increase readiness for behavioral health treatment include accurate communication about the treatment program, its services, and its effectiveness; a considerate and respectful approach; affordable housing and medical and dental care; vocational services; and participants'

experiences and satisfaction with services (Acosta & Toro, 2000; Freund & Hawkins, 2004; O'Toole, Conde-Martel, et al., 2004; Sosin & Grossman, 2003). In a study in Baltimore, 42 percent of people contacted through street outreach (n=4,428) were engaged into substance abuse treatment services by using many of the aforementioned approaches (Tommasello et al., 1999).

Personal factors that increase readiness for substance abuse treatment among people who are homeless relate to problem recognition, desire for help, childcare responsibilities, and physical health problems (Nwakeze, Magura, & Rosenblum, 2002). Factors that predicted greater recognition of substance use/abuse problems were a diagnosis of depression, previous treatment experience, and having a job and/or job skills. Factors significantly associated with more desire for help were intensive drug use patterns, higher frequency of use, and more recognition that substance use was causing personal problems. Gerdner and Holmberg (2000) suggest that people who believe they have a lot to lose by continuing their substance abuse are more motivated to enter treatment than those who believe they have nothing to lose. In a sample of 274 persons who sought care in a public detoxification center (61 percent of whom had experienced homelessness in the prior 6 months), use of subsequent treatment services was associated with higher levels of motivation for abstinence from substance use and with higher perceived consequences of substance abuse (Kertesz, Larson, et al., 2006). Persons whose social environments had higher rates of substance abuse were less likely to enter substance abuse treatment.

Access to Behavioral Health Services

In spite of a demonstrated need for services, people who are homeless often encounter barriers to accessing behavioral health services. Those who do not seek health services tend to have higher levels of substance use disorders than those who do seek services (Tommasello et al., 1999), and those with substance use disorders who do not enter substance abuse treatment are more likely to be living on the streets than in shelters (Nyamathi et al., 2000).

In a study of people who were homeless in Philadelphia , PA, and Pittsburgh, PA (N=531), 72 percent met criteria for a substance use disorder. Of these, 50 percent did not receive treatment in the previous year; 77 percent of those who received treatment did not feel it was adequate and would have sought more if it were available (O'Toole, Freyder, et al., 2004). Reasons for not being able to access additional treatment (n=72) included a lack of insurance or money to pay (56 percent), changing their mind while on a waiting list (49 percent), or programs being full (47 percent).

People who are homeless also experience significant barriers to accessing methadone maintenance services. Deck and Carlson (2004) reviewed records for 8,362 Medicaid-eligible individuals from Oregon and 10,604 from Washington State who entered substance abuse treatment between 1992 and 2000 with opioids as their primary substance of abuse. Being homeless significantly reduced the odds that these clients would receive methadone, even though Medicaid would pay for it (the OR in Oregon was 0.29; in Washington, 0.55). A study that used data from SAMHSA's 1998 TEDS found that people who were homeless and eligible for methadone maintenance treatment were significantly less likely to be placed in methadone maintenance than were people who were housed (Rivers, Dobalian, Oyana, & Bae, 2006). Similarly, an evaluation of treatment entry between 1996 and 1999 of people using injection

drugs in Massachusetts (*N*=32,173) found that people who were homeless were significantly less likely than people who were housed to enter methadone maintenance treatment (Lundgren, Schilling, Ferguson, Davis, & Amodeo, 2003).

The use of assertive community treatment (ACT) teams (see the discussion in the "Assertive Community Treatment" section) can also improve treatment entry for people who are homeless. Bradford et al. (2005) describe a shelter-based intervention in which the clients who worked with the same psychiatric social worker and psychiatrist throughout the intervention entered substance abuse treatment and mental health services at higher rates than did clients who received standard consultation and met with whatever program psychiatrist was available. Of those who received the intervention, 51 percent entered a substance abuse treatment program or went on to attend both a screening session and at least one follow-up session, whereas just 13 percent of those who received standard psychiatric services did so.

Treatment Retention

Retention of people who are homeless may be a problem for all types of behavioral health services, but research on the subject relating to people who are homeless has focused almost entirely on substance abuse treatment services. However, many of the strategies suggested by this research can also be applied to clients being treated for mental disorders.

Erickson, Stevens, McKnight, and Figueredo (1995) found that length of stay in substance abuse treatment and greater improvements in substance use and housing outcomes were related to motivation, readiness, and suitability for treatment. Dropout rates are high for people who are homeless in substance abuse treatment—up to 90 percent according to some studies (Sosin & Grossman, 2003). One multisite, multiple-intervention evaluation found that retention was a greater problem in substance abuse treatment programs for people who are homeless than in programs that treat the general population (Orwin, Garrison-Mogren, Jacobs, & Sonnefeld, 1999). Most of the 15 programs evaluated lost more than 80 percent of their clients. Common reasons for dropping out were lack of motivation; desire to return to family, friends, or prior activities; delayed start to treatment (e.g., being on a waiting list before entering the program); dissatisfaction with program structure or demands; dissatisfaction with program environment (e.g., lack of privacy, lack of activities); difficulty finding transportation; and perceiving no value in program activities.

To improve retention, Orwin et al. (1999) suggest that providers:

- Eliminate or decrease waiting times between enrollment and entry.
- Orient clients with a realistic view of program expectations.
- Increase contact with case managers.
- Make services more accessible (e.g., by scheduling more hours when services are available).
- Improve program facility environment.
- Improve responsiveness to client-specified needs (e.g., housing).
- Invite families to come to the program early to increase their understanding of the program.
- Increase opportunities for recreation and self-improvement.
- Improve relapse prevention efforts.

Orwin et al. (1999) also found that providing housing had the single greatest effect on improving retention. Burt and Anderson's (2005) evaluation of State-funded supportive housing programs for people with SMI in California supports this finding. They found the correlation of the percentage of clients housed and the percentage of clients retained by those programs to be 0.929 (see also the "Housing" section).

For women who are homeless and have children in their care, residential programs that allow those children to remain with the client are more likely to retain those clients than programs where women are separated from their children. Research conducted largely with women with children who were not homeless has found this to be the case (for more information, see TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* [CSAT, 2009d]). One study conducted with women who were homeless also appears to confirm it. Smith, North, and Fox (1995) compared an outpatient treatment program—where women attended treatment during the day with their children but had to find their own housing (with or without their children) after treatment concluded (n=82)—with a residential TC program where women lived on site with their children (n=67). The clients assigned to day treatment were more likely to miss their first session and to drop out once treatment began. However, dropout rates were high for both groups, with 75 percent of the nonresidential group and 50 percent of the residential group leaving by week 12 of the 1-year program. Supportive housing programs that allow single parents with SMI to stay with children are also becoming available, and one such program suggests that it is having a positive effect on both parents and children (Emerson-Davis Family Development Center, 2000); however, formal evaluations of such programs have been and remain a challenge (Nicholson, Hinden, Biebel, Henry, & Katz-Leavy, 2007; O'Campo et al., 2009).

Other research indicates that, among veterans who were homeless when they entered a program that combined substance abuse treatment with social and vocational rehabilitation (N=596), women were more likely to be retained in treatment than men, and those who were younger (i.e., in their 20s) were more likely to be retained in treatment than those who were 50 or older (Justus, Burling, & Weingardt, 2006). People with depressive disorders had higher retention rates than those without, whereas those with current personality disorders had lower rates.

Stahler, Cohen, Greene, Shipley, and Bartelt (1995) interviewed men who were in substance abuse treatment, diagnosed with cocaine use disorders, and homeless. The men rated sobriety as their primary indicator for treatment success. They also endorsed being better able to deal with emotions, handle money, take responsibility for their own lives, handle stress, develop and pursue personal goals, get and hold a job, find and stay in housing, and have a more positive self-image. Client and program attributes endorsed by both clients and providers were (in order of importance) client self-motivation; a program treatment culture with strong, supportive relationships among fellow clients and staff; 12-Step meetings offered on site or nearby in the community; and social support from clients' relatives and friends.

Kraybill and Zerger (2003) described six substance abuse treatment programs that have made changes to better serve clients who are homeless. Program modifications include placing high priority on obtaining stable housing; a holistic, client-centered approach; and developing strong relationships.

Behavioral Health Interventions

A wide range of evidence-based treatment modalities and interventions are available to aid in the treatment of people who are homeless and have behavioral health disorders. Many of these interventions are applicable regardless of whether the clients have substance use and/or mental disorders. A few interventions specific to mental health or substance abuse treatment settings are also discussed in the "Treatment Settings" section. The discussion in this section highlights only those interventions that have been evaluated specifically with people who are homeless.

Few data, however, are available comparing different behavioral health interventions for this population. O'Campo et al. (2009) reviewed 10 effective or promising programs for this population and extracted six core principles that help reduce mental and substance disorders among people who are homeless:

1. Placing an emphasis on client choice in making decisions about treatment.
2. Developing positive relationships between clients and providers.
3. Using ACT approaches to service delivery.
4. Providing housing (particularly supportive housing).
5. Helping clients with instrumental needs (e.g., food, recreation, money management).
6. Having flexible, nonrestrictive policies.

Motivational Interviewing

Motivational interviewing (MI) is incorporated into many services for working with people who are homeless, including substance abuse treatment; transitional, permanent, and supportive housing programs; ICM services; and outreach services (Fisk, Sells, & Rowe, 2007; Kraybill & Zerger, 2003; NIAAA, 2005; Winarski et al., 1998). MI is a semidirective, client-centered counseling style that elicits behavior change by helping clients explore and resolve ambivalence. It facilitates the development of the trusting relationship and the decision to make a change. Bernstein et al. (2005) found that a brief motivational intervention delivered in a walk-in healthcare clinic by peer counselors was associated with improved abstinence rates and reductions in opioid and cocaine use (measured by hair testing). Of their total sample (*N*=1175), 43 percent of the intervention group and 49 percent of the control group were homeless. More information on motivational interviewing can be found in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT, 1999b).

Community-Based Intensive Case Management Services and Treatment

Integrated ICM teams and ACT teams can effectively engage people who are homeless and have substance use and/or mental disorders into services. ACT is the more clearly defined model, but both involve a greater level of case management than is typically available. (For a detailed comparison, see Schaedle, McGrew, Bond, & Epstein, 2002.) For people with mental disorders, case management can improve symptoms of mental illness, and ACT can decrease psychiatric hospitalizations; for those with substance use disorders, case management is associated with greater reductions in substance use than usual care (see the review by Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005).

Intensive case management

ICM effectively engages people who are homeless into services that would otherwise be difficult to access. ICM includes assertive and persistent outreach, reduced counselor caseloads, participant-set priorities, development of trusting relationships, and active assistance in accessing needed resources. The case manager (or counselor, as appropriate) follows the client through transition into services and provides support until the client is able to function either independently or in mainstream services without ICM support. See TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT, 1998a), and TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c), for more information on ICM services.

As discussed in the "Assertive Community Treatment" section, when high-quality, integrated clinical case management services and appropriate community resources are available, ICM for people who are homeless can be as effective as ACT (Essock et al., 2006). However, according to a review by Nelson, Aubry, and Lafrance (2007), the sizes of effects on housing for ICM interventions are smaller than those seen with ACT interventions, and both are smaller than supportive housing interventions.

Morse (1999) outlines four reasons why providers consider ICM an important service for people who are homeless:

1. People who are homeless have multiple, often extensive, unmet needs.
2. The services needed by people who are homeless are often delivered through a fragmented system of care involving multiple providers.
3. The structure of the service system often presents barriers for people who are homeless, making it even more difficult for them to access services.
4. Case managers are able to facilitate access to services and coordinate services from multiple providers in ways other staff might not be able to or have time for.

Kilbourne et al. (2002) found that women who were homeless (N=974) and had a case manager were less likely to inject drugs than those who had no case manager. Another study found that people diagnosed with alcohol dependence who were chronically homeless or at high risk of homelessness and had a case manager demonstrated improved income from public programs, increased number of nonhomeless nights, and decreased number of days drinking (Cox et al., 1998).

Adding ICM to behavioral health services that have readily available, easily accessed, comprehensive services was found to have little effect on treatment outcomes. This suggests that such services may have a greater impact in environments featuring available, but not easily accessed, services (Braucht et al., 1995; Conrad et al., 1998). Rosenheck (2010) reviewed a few studies that demonstrate that ICM is usually cost effective when used with people with behavioral health disorders who are homeless.

Critical time intervention

Critical time intervention (CTI) is an evidence-based ICM approach developed by Susser et al. (1997) to assist clients in the transition from shelter to community. CTI emphasizes the case

manager's continued support of the client before, during, and after a housing or service transition is made. The point of CTI is that, after discharge from an institutionalized environment, people with mental disorders need high-level services to keep them engaged in order to prevent homelessness and worsened behavioral health problems. CTI has been applied in other stressful transitional situations as well.

CTI case managers follow clients closely—for example, making home visits and negotiating client needs with new service providers long after a housing or other service transition (see the description in Herman & Mandiberg, 2010). CTI can prevent recurring homelessness among people with mental disorders who are or were homeless (Jones et al., 2003; Kasprow & Rosenheck, 2007; Lennon, McAllister, Kuang, & Herman, 2005; Susser et al., 1997). CTI is also associated with significant reductions in drug and alcohol use for veterans with mental disorders (Kasprow & Rosenheck, 2007) and with significant reductions in negative symptoms of schizophrenia (measured with the Positive and Negative Syndrome Scale) for men with psychotic disorders (Herman et al., 2000). In Canada, a program similar to CTI for people with no fixed address upon discharge from psychiatric wards also has been used with excellent results (Forchuk et al., 2008).

Jones et al. (2003) compared the effects of CTI and a "usual care" condition at multiple VA sites. The usual care condition included referrals to mental health, rehabilitation, and other community programs. Participants in this condition could contact their shelter case managers, but the managers did not visit them or actively arrange for services beyond initial transition to housing. The study showed CTI to be cost effective when the costs incurred during the 9 months of intervention were compared with costs incurred during the 9 months following intervention (Jones et al., 2003). The CTI group experienced 58 fewer homeless nights than the usual care group over an 18-month period, and the additional cost of CTI was estimated to be $152 per nonhomeless night. More information on CTI is provided on the National Registry of Evidence-Based Programs and Practices (NREPP) Web site (http://nrepp.samhsa.gov/).

CTI, with the addition of services related to family preservation and parenting skills, has also been adapted for use with families with young children who are homeless (Samuels, 2010). A program evaluation of family CTI (FCTI) for single mothers with mental and/or substance use disorders who were homeless found that, at an assessment 15 months after program entry, participants in FCTI were significantly more likely to be in permanent or transitional housing and to have had substance abuse treatment than were mothers in the control group (Samuels, Shinn, Fischer, Thomkins, & Park, 2006).

Assertive community treatment

ACT was originally developed to help people with SMI who were living in the community and would otherwise be at high risk of institutionalization. ACT features teams made up of multidisciplinary staff, including social workers, nurses, psychiatrists, substance abuse counselors, specialists in supported employment, peer counselors, and others. As applied to homeless populations, ACT places participants in housing in the community (either congregate or scattered site) and the ACT team is located off site. Many services are provided in the participants' natural environments (e.g., apartment, workplace, neighborhood). Participants are engaged into treatment and other services through frequent contacts, a team approach with

manageable caseloads, and a long-term commitment from the ACT team. To accommodate the needs of people who are homeless and diagnosed with CODs, ACT teams should include outreach workers, peer advocates, and family outreach coordinators (Lehman, Dixon, Hoch, et al., 1999; Lehman, Dixon, Kernan, et al., 1997). These modifications are associated with greater satisfaction with family relations and more stable housing (Hackman & Dixon, 2006). Other modifications include the use of small teams made up of a case manager, a psychiatrist, and a consumer advocate, and also the use of drop-in and office-based services (Hackman & Dixon, 2006).

Coldwell and Bender (2007) conducted a meta-analytic review of 10 studies of ACT interventions for people with SMI who were homeless, involving a total of 5,775 participants. They found that, in six randomized trials that made comparisons with standard case management, ACT resulted in a 37 percent greater reduction in homeless and a 26 percent greater improvement in mental disorder symptom severity. In four observational studies, more improvements in housing and mental disorder outcomes were seen.

Another review of interventions to improve health (both behavioral and physical) among people who are homeless also discussed research on ACT (Hwang et al., 2005). These authors found good data supporting the claims that ACT can, for people with mental disorders, reduce some types of mental disorder symptoms and psychiatric hospitalizations, but they cautioned that not all studies have found such effects on mental disorder symptoms associated with ACT use.

Morse (1999) reviewed research on ACT for people who were homeless and had mental disorders. He concluded that there was extensive research supporting the effectiveness of ACT in helping that population obtain stable housing and other needed services and somewhat less, but still promising, research suggesting that ACT was effective in reducing mental disorder symptom severity; reducing inpatient hospitalization and emergency room use; engaging and retaining people in treatment; and increasing family contacts, life satisfaction, income, self-esteem, employment, and social interaction. A couple of the studies reviewed also addressed substance abuse outcomes for people with CODs, suggesting that use of ACT was associated with better substance abuse outcomes than brokered case management and better retention and housing stability for all but those with the most severe substance use disorders.

The 5-year multisite ACCESS demonstration program examined the effectiveness of system-change strategies for improving interagency collaboration in providing services to people who were homeless and had SMI and CODs (Randolph et al., 2002). Part of this project was an evaluation of intensive outreach and time-limited ACT services. Rosenheck and Dennis (2001) looked at outcomes for clients who received 12 to 18 months of ACT services in the fourth annual cohort of ACCESS. At an 18-month assessment, people who received more treatment had improved outcomes on measures of drug use and housing, but clients who were discharged from the program according to ACT team clinical judgment did not have significantly different outcomes from those who continued in the program for the full length of the study. In addition, participation in ACCESS was associated with significant decreases in psychiatric hospitalizations and increases in the use of outpatient services. After entering ACCESS, participants also experienced better continuity of care following hospital episodes, suggesting that the program was effective at linking participants to services in their communities (Rothbard, Min, Kuno, & Wong, 2004).

Kenny et al. (2004) compared ACT (*n*=105) and brokered case management (*n*=60) for people with SMI who were homeless; they also explored possible mediating or moderating factors related to ACT outcomes. Participants who received ACT had better outcomes in terms of housing and mental disorder symptoms. Housing outcomes were partially mediated by case management assistance with housing and financial assistance, but none of the mediating or moderating factors the researchers evaluated had a significant effect on mental disorder symptom outcomes.

In ACT, the appropriate level of service intensity depends on the participant's needs and the accessibility and availability of integrated services in the community. In a randomized trial, Essock et al. (2006) compared ACT and integrated intensive clinical case management. Participants (*N*=198) were homeless and diagnosed with a major psychotic disorder and an active substance use disorder; they had high levels of medical/mental health service use and poor independent living skills. ACT team services were similar to those previously described and had a staff–participant ratio of 1:10 or 1:15. The intensive clinical case management teams comprised clinicians from different disciplines and had individual caseload ratios of about 1:25. The two conditions were equally effective at reducing substance use after 3 years, with about one third of all participants achieving substance use remission. ACT services reduced hospitalization significantly at the site that had higher hospitalization rates. The authors suggested that the findings were affected by the quality of the community programs at both sites and the incorporation of many ACT values and techniques into the intensive clinical case management services. They concluded that the structure of service delivery is less important than developing and maintaining necessary skill sets among treatment staff. However, ACT is the preferred integrated treatment delivery model when high-quality, integrated clinical case management services and appropriate community resources are lacking.

In a small study (*N*=85) of cost-effectiveness, average costs of two different ACT models (one involving the addition of community workers to aid clients in community participation) did not differ significantly from that of brokered case management in spite of significantly better outcomes in a number of areas for ACT participants (Wolff, Helminiak, Morse, & Calsyn, 1997). Costs were about 12 percent lower for the ACT model that added a community worker compared with standard ACT, but the difference was not significant.

Interventions to Improve Social and/or Family Support

People who are homeless, especially those with behavioral health disorders, typically have very low levels of social and/or family support (Lam & Rosenheck, 1999). Improving the connections people who are homeless have with their social support systems (e.g., family, friends, mutual-help groups) may help prevent a return to homelessness after treatment completion.

Research has found that, among those who are homeless, greater emotional support from informal social networks is associated with better mental health (as measured with the SF-12) (Hwang et al., 2009). Outside of treatment settings, informal social networks (involving support from family and friends) also play an important role in recovery for people with behavioral health disorders who are or recently have been homeless (Wong, Matejkowski, & Lee, 2011). Lam and Rosenheck (1999) analyzed data from the ACCESS program regarding social support and service use. They found that greater social support (whether from family or friends) was

associated with the use of significantly more services, and certain types of support (e.g., greater contact with one's family of procreation) were associated with significantly more frequent use of certain types of services (e.g., medical services).

Zlotnick, Tam, and Robertson (2003) followed 397 individuals who were homeless for a 15-month period and found that support from family, friends, and social services shortened the course of homelessness, but only for people who did not meet diagnostic criteria for a current substance use disorder. The authors speculated that current substance use interferes with the benefits of connecting to social supports. Another study, involving 4,778 adults with SMI who were homeless (43 percent of whom also had alcohol dependence and 39 percent of whom had drug dependence), found that more contacts with family and greater satisfaction with family relationships were both associated with significantly more days in stable housing (Pickett-Schenk, Cook, Grey, & Butler, 2007).

On the other hand, a lack of social support likely has a detrimental effect on behavioral health treatment outcomes and participation. Kingree, Stephens, Braithwaite, and Griffin (1999) found that among low-income individuals who had completed a residential substance abuse treatment program, the only significant risk factor (among those measured, including continued substance use) for subsequent homelessness was lack of social support.

In a study of sources and types of support for 252 individuals with SMI who were residing in supportive housing, family (rather than friends or service staff) was the greatest source of emotional, tangible, and problem-solving support, although also the greatest source of negative interactions (Wong, Matejkowski, & Lee, 2011). Participants also reciprocated support with family more often than with friends or providers, which is important given that mutual exchanges of tangible and problem-solving support were significantly associated with satisfaction with one's social network, as was having more people involved in such transactions.

Interventions, such as filial therapy, are also available to help parents who are homeless with their dependent children improve family relations. Kolos, Green, and Crenshaw (2009) describe how to implement such programs and their potential benefits.

Peer Counselors, Faith-Based Supports, and Recovery Supports

Peer counseling and other forms of peer assistance are a low-cost way to assist clients. Building social support from peers, in and of itself, can improve behavioral health disorders. As noted above, under "Interventions to Improve Social and/or Family Support," building social support from peers can improve outcomes for people with behavioral health disorders who are homeless. This can take the form of developing a peer mentoring program or linking clients to existing peer support groups such as 12-Step groups (e.g., Alcoholics Anonymous [AA], Narcotics Anonymous [NA], Double Trouble in Recovery) or the National Alliance on Mental Illness' (NAMI's) Connection Recovery Support Groups.

Stahler et al. (1995) found that shelter-based case management provided primarily by peers produced results comparable to those for standard case management services provided by professionals in an integrated, comprehensive, residential behavioral health treatment program. For a group of African American women who were homeless and currently living at a residential

treatment program, the addition of peer mentors (drawn from African American churches and other faith communities) improved retention, client satisfaction with the program, and long-term abstinence (according to self-report 18 months after treatment) (Stahler et al., 2005). Bernstein et al. (2005) also found that a brief, peer-delivered motivational interview delivered during health clinic visits was effective in reducing substance use among people who were homeless.

In a small study (*N*=18), Boisvert, Martin, Grosek, and Clarie (2008) found significant improvements in Medical Outcomes Study Social Support Survey subscales reflecting emotional support, tangible support, and affectionate support as well as significant decreases in relapse rates after instituting a peer support program in a supportive housing environment.

Consumer-run drop-in centers for people with mental disorders are valuable sources of peer support for people who are homeless (see the description of these programs in Brown, Wituk, & Meissen, 2010). Although research has not been conducted exclusively with people who are homeless, studies do indicate that such centers are effective at improving well-being and social functioning for people with mental disorders (see reviews by Campbell, 2005; Teague, Johnsen, Rogers, & Schell, 2011). Participant comments and clinical observations from a peer-run drop-in center for people with SMI (a large percentage of whom were homeless) suggest that such programs can build self-esteem and serve as sources of social support (Schutt & Rogers, 2009).

Wong, Nath, and Solomon (2007) described a variety of groups and organizations being used by people with SMI who were residing in supportive housing (e.g., 12-Step groups, mental health clubhouses, advocacy groups, faith-based organizations). Participation in mutual-help groups, in particular, benefited people who were homeless and had behavioral health disorders. In research by Gonzalez and Rosenheck (2002) with people with CODs who were homeless, participants with a high level of participation in mutual-help groups had significantly better outcomes on measures of alcohol-related problems than did those with no or little participation in mutual-help groups. Participation in these groups was strongly associated with the use of professional treatment services. The planned TIPs, *Behavioral Health Services: Building Health, Wellness, and Quality of Life for Sustained Recovery* (SAMHSA, planned c) and *Recovery in Behavioral Health Services* (SAMHSA, planned g), contain more information on the use of mutual-help groups to support people with behavioral health disorders.

Medication-Assisted Treatment

Various medications are now available to treat both substance use and mental disorders, but people who are homeless may have more problems accessing and using such medications. Research suggests that a significant percentage of all people who are homeless have trouble complying with any medication regimens (Kushel, Vittinghoff, & Hass, 2001), and rates of noncompliance are higher for people with SMI who are prescribed psychotropic medications (see, e.g., Dixon, Weiden, Torres, & Lehman, 1997).

Medications for mental disorders

Adherence to medication regimens is an issue for clients who are homeless; they can have difficulties understanding medication instructions, keeping to a schedule, obtaining medication,

and storing medication once it is obtained (Morrison, 2007). Gilmer et al. (2004) found, in an analysis of 2 years of Medicaid data for 2,801 individuals with schizophrenia, that being homeless was associated with the lowest adherence rate (only 25.9 percent of those who were homeless adhered to prescribed regimens) of any of the variables they analyzed.

Helping clients who are homeless obtain insurance benefits (see the "Help Obtaining Public Assistance" section) can significantly reduce barriers to medication compliance (Kushel, Vittinghoff, & Hass, 2001). Providing treatment that helps clients manage housing and other service needs may also improve adherence. Dixon, Weiden, Torres, and Lehman (1997) looked at medication adherence among a group of 77 people who were homeless and had SMI before and after they entered an ACT program. Although 29 percent adhered to medication regimens before entering the program, that percentage increased significantly to 57 percent 3 months after program entry and fell only slightly from the 3-month level at 1 year after entry.

Supported housing environments also appear helpful in promoting medication adherence. Magura et al. (2002) found a significant association between supportive housing and adherence in their study of 240 individuals with CODs attending Double Trouble in Recovery meetings. Velligan et al. (2010) reviewed findings from an expert clinical survey regarding treatment adherence for people with SMI, which, although not specific to clients who are homeless, may be helpful in making decisions about medications for this population. For clients with severe psychotic symptoms who are consistently noncompliant with medication regimens, providers can consider outpatient commitment (Torrey & Zdanowicz, 2001) or the use of long-acting, injectable antipsychotics (Velligan et al., 2010).

Medications for substance use disorders

A variety of old and new medications are currently being used to help people with substance use disorders better manage recovery. For some of these medications (e.g., acamprosate, naltrexone), there is no information available specifically regarding use with people who are homeless. A number of TIPs address medication-assisted treatment for substance use disorders—particularly TIP 43, *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (CSAT, 2005a), and TIP 49, *Incorporating Alcohol Pharmacotherapies Into Medical Practice* (CSAT, 2009c).

Alford et al. (2007) compared clients receiving office-based buprenorphine treatment who were homeless (n=44) and domiciled (n=41) and found no significant differences in treatment failure, illicit opioid use while in treatment, use of counseling, or participation in mutual-help groups despite the higher COD rates, fewer social supports, and more chronic substance abuse histories of clients who were homeless. However, clients who were homeless did require more clinical support during their first month in treatment than did clients who were housed.

Although cost is an issue, medications for smoking cessation can also be considered with this population. Researchers who interviewed 165 people who were homeless and smoked found that 37 percent reported readiness to quit within the next 6 months, 42 percent stated that the assistance they most wanted for quitting was nicotine replacement (either alone or in combination with counseling), and 14 percent stated a preference for bupropion (either alone or in combination with counseling) (Connor et al., 2002). Another study, which gathered

information from focus groups with people who were homeless and smoked (*N*=62), found that about 44 percent of subjects had used nicotine replacement products in the past and 15 percent had previously used bupropion (Okuyemi et al., 2006). Participants were interested in using pharmacological aids for smoking cessation, but their preferred medications varied according to how much information they were given. Groups who were shown just the products preferred nicotine gum or the nicotine patch; those who received more detailed information preferred bupropion followed by a nicotine inhaler. However, many participants believed that bupropion had possible mood-altering effects and would have "street value" if diverted for recreational use.

Integrated Treatment for Co-Occurring Disorders

A number of studies have found that integrated treatment that provides coordinated services for substance abuse and mental health, along with housing, is effective with people who are homeless and have CODs. It can improve outcomes related to psychiatric hospitalizations, substance abuse, and housing (Drake, Mueser, Brunette, & McHugo, 2004; Essock et al., 2006; Kasprow, Rosenheck, Frisman, & DeLella, 2004; Moore, Young, Barrett, & Ochshorn, 2009; Tsai, Salyers, Rollins, McKasson, & Littmer, 2009). For example, Moore et al. (2009) evaluated an integrated treatment model (comprehensive, continuous, integrated system of care) with 48 people with CODs who were homeless; 12 months after treatment entry, significant improvements in housing, employment, mental health, and substance use outcomes were found. CMHS's ACCESS program study (see description in the "Assertive Community Treatment" section) also uses an integrated treatment model. It has been found, compared with controls, to be associated with significantly better housing outcomes for participants (see, e.g., Cheng & Kelly, 2008).

However, Morse et al. (2006) found no significant differences in outcomes between an integrated ACT program (*n*=46) and a nonintegrated ACT program (*n*=54) for participants with CODs who were homeless, although participants in both had significantly better outcomes than clients who received standard treatment (*n*=49). This may show that the benefit provided by integration can be provided using other means. These researchers did find the integrated ACT model to be more cost effective than the standard ACT care.

Trauma-Informed and Trauma-Specific Services

Trauma-informed services "take into account knowledge about trauma—its impact, interpersonal dynamics, and paths to recovery—and incorporate this knowledge thoroughly in all aspects of service delivery" (Finkelstein et al., 2004, p. 1), whereas trauma-specific services "address directly the impact of trauma on people's lives and…facilitate trauma recovery and healing" (Finkelstein et al., 2004, p. 1). For more information on trauma-informed and trauma-specific services, see the planned TIP, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA, planned j).

Lester et al. (2007) examined treatment outcomes for clients with CODs who were homeless and participated in abstinence-contingent housing and vocational services with or without behavioral day treatment (*N*=118). Clients in either condition who had symptoms of trauma or PTSD had fewer trauma symptoms over the 6-month treatment period. Greater positive distraction coping (e.g., focusing on one's job to take one's mind off things, trying to see problems in a different

light) and lower negative avoidance coping (e.g., using substances, ignoring problems) at baseline, in addition to decreased avoidance coping over the 6-month study period, were significantly related to fewer trauma symptoms. The authors concluded that even though specific trauma treatment might not be available, assessment of trauma symptoms and PTSD along with emotional processing and an emphasis on adaptive coping in treatment sessions can reduce trauma symptoms. Additionally, screening for trauma and PTSD can improve the accuracy of assessments of clients' needs.

One model for addressing PTSD in individuals with substance use disorders that has been used successfully with women who are homeless is the trauma recovery and empowerment model (TREM) (SAMHSA, 2007). Another model, the Seeking Safety intervention for women with histories of trauma and substance use disorders, was evaluated by Desai, Harpaz-Rotem, Najavits, and Rosenheck (2008) with female veterans who were homeless. The authors found that it resulted in moderate improvements in clinical outcomes compared with standard VA system care. More information on TREM and Seeking Safety is provided on the NREPP Web site (http://nrepp.samhsa.gov/).

Contingency Management and Community Reinforcement Approaches

Unlike the other interventions discussed in this section, contingency management (CM) approaches have been largely confined to the treatment of substance use disorders, although they may be applied to other behavior issues such as HIV medication adherence (Sorensen et al., 2007). CM has been found effective in research studies for promoting abstinence from substance use during treatment. It can improve the ability of clients to remain abstinent and allows them to take fuller advantage of other clinical treatment components (see review by Prendergast, Podus, Finney, Greenwell, & Roll, 2006). In CM approaches, clients earn vouchers and/or have the opportunity to win prizes or privileges as they achieve abstinence and other behavior change goals. In voucher-based CM, clients earn vouchers exchangeable for retail items contingent on objectively verified abstinence from recent drug use or compliance with other behavior change goals. For people who are homeless, preferred housing can also be used as a contingency as part of an abstinence-contingent housing program. More information on this model can be found in the "Behavioral Day Treatment With Abstinence-Contingent Housing and Work Therapy" section.

CM with people who are homeless and have cocaine use disorders has been consistently shown to produce higher abstinence rates compared with interventions that do not include CM (see review by Schumacher et al., 2007). CM has also been used with an out-of-treatment population of men who have sex with men and who are homeless, and its use was found to be associated with significant reductions in the quantity of substance use and increases in health-promoting behaviors (Reback et al., 2010). Overall, CM has been found to be an effective tool for improving treatment outcomes across substance abuse treatment populations (Olmstead, Sindelar, & Petry, 2007).

The community reinforcement approach (CRA) uses social, recreational, familial, and vocational reinforcements to assist clients in recovery from substance use disorders. Its goal is to make a sober lifestyle more rewarding than the use of substances. Three meta-analytic reviews, not specific to people who are homeless, cited it as one of the most cost-effective alcohol treatment

programs available (Finney & Monahan, 1996; Holder, Longbaugh, Miller, & Rubonis, 1991; Miller & Hester, 1995).

Smith et al. (1998) compared a 3-month CRA program for people who were homeless and diagnosed with alcohol dependence (*n*=64) with a standard shelter-based program (*n*=42). The shelter-based program was a day shelter offering basic meals, clothing, showers, a job program, individual sessions with AA-oriented counselors, and onsite AA meetings. Participants in the CRA condition were treated in a group therapy format, and two weekly prizes were awarded for good attendance. The focus of most groups was skills training, primarily in the areas of problem-solving, communication, and drink refusal. Periodically, group sessions were supplemented with relationship counseling or case management meetings. Participants in the CRA condition were housed in grant-supported apartments, and those who were employed at the end of 3 months were allowed to remain in the apartments for an additional month. Housing privileges were suspended temporarily if random breathalyzer tests detected drinking. Compared with standard care at the shelter, those treated with CRA showed significantly better outcomes throughout a year of follow-up. Participants in the community reinforcement intervention had fewer drinks per week, fewer days of drinking per week, and a lower peak blood alcohol content rating. However, few differences in employment or housing outcomes were observed.

Other Services

People who are homeless have a wide range of often pressing needs, which may need to be addressed in order to improve treatment retention and outcomes. This section discusses some of the services that might lie outside traditional mental health and substance abuse treatment services. Note that housing services are discussed separately (see the "Housing" section).

Occupational Therapy

As Muñoz, Garcia, Lisak, and Reichenbach (2006) note, the importance of an occupational therapy (OT) perspective in services for people who are homeless is now well recognized. Citing research with this population, they argue that "occupational therapists are well-suited to provide core services at homeless shelters" (p. 136). These services may be especially salient for clients with behavioral health disorders.

A number of studies have explored the OT needs of people who are homeless. From a review of other studies involving OT for people who are homeless (although not confined to those with behavioral health disorders), Finlayson, Baker, Rodman, and Herzberg (2002) concluded that the primary OT-related needs for this population are finding a place to live, finding a job, improving job skills, managing money, getting along with other people, handling resource issues, and handling legal issues. Muñoz et al. (2006) studied 65 participants who were homeless in an OT supportive employment program, the majority of whom (92 percent) had received treatment for substance use disorders and many of whom (68 percent) had received treatment for a mental disorder. They found that the most common need—present for 59 percent of participants—was improved self-care (e.g., staying sober, improving physical health, legal issues, resource management, transportation), followed by productivity for 31 percent (e.g., gaining employment, education, computer skills) and leisure skills for 10 percent (e.g., improving interpersonal relationships, learning to manage quiet time). One small study of parents who were homeless

(*N*=12) found that they seemed to expend a substantial amount of energy to create or maintain family routines while living in a homeless shelter (Schultz-Krohn, 2004). The author suggests that OT services may assist these parents in their roles as organizers of family routines.

Herzberg, Ray, and Miller (2006) conducted an Internet-based survey of assessment tools used by OT practitioners working with persons who were homeless. Exhibit A lists the most commonly used standardized assessments and the areas they assess: The Kohlman Evaluation of Living Skills (McGourty, 1999), the Allen Cognitive Level Screen (Allen, 1997), and the Canadian Occupational Performance Measure (Law et al., 1998). Herzberg et al. (2006) noted that all tools (standardized and therapist developed) appropriately emphasized a holistic approach (strengths as well as challenges) and an emphasis on client priorities.

A small study of an intervention for women who were homeless illustrates the potential contribution of OT to homelessness services (Gutman et al., 2004). Participants were 26 women residing in a homeless shelter. More than half the women had experienced or were currently experiencing domestic violence, 88 percent had a mood disorder, 35 percent had PTSD, and 50 percent had a history of substance abuse. The intervention addressed safety planning, drug and alcohol awareness, safe sex practices, assertiveness and advocacy skill training, anger management, stress management, boundary establishment and limit setting, vocational and educational skill training, money management, housing application, leisure exploration, hygiene, medication routine, and nutrition. Goal Attainment Scaling (Ottenbacher & Cusick, 1990) was used to assess the accomplishment of client-generated outcomes, and the results indicated that 21 clients (81 percent) were able to achieve the highest level of goals they had set for themselves.

Vocational Training/Work Therapy

A large percentage of people who are homeless can be served successfully by employment and training programs (Trutko, Barnow, Beck, & Rothstein, 1994), and this includes individuals with behavioral health disorders. Having received job training and/or assistance finding employment was associated with significant increases in the likelihood of having been employed in the month prior to assessment for individuals who were homeless, had SMI, and were enrolled in the

Exhibit A: Commonly Used OT Assessment Tools for Homeless Populations

Assessment Tool	Assesses
Kohlman Evaluation of Living Skills	• Activities of daily living (ADLs), self-care, home management • Community safety and money management • Client's needs for skills in independent living
Allen Cognitive Level Screen	• Cognitive ability related to work, ADLs, independent living • Interpersonal communication
Canadian Occupational Performance Measure	• Building collaboration and developing client goals • Client's perception of level of own functioning and areas of dysfunction • Client's view of important occupations • Prioritizing interventions

ACCESS demonstration program (Pickett-Schenk et al., 2002). In that study, with the exception of schizophrenia, mental disorders did not have a significant effect on employment histories.

The U.S. Department of Labor's evaluation of the Job Training for the Homeless Demonstration Program (*N*=20,660) found that the program successfully placed about one third of participants in jobs (*n*=7,027) (Trutko et al., 1994). Of the total sample, 36 percent were considered "chemically dependent" (either self-identified or identified by case managers as having a level of substance use that would interfere with employment), and 11 percent were similarly identified as "mentally ill," but the report noted that these percentages substantially underestimate the percentage of participants with mental and/or substance use disorders. The most common barriers to employment for program participants were lack of transportation (affecting 43 percent), lack of job skills/training (35 percent), and minimal work history (25 percent). Participants classified as chemically dependent were more likely to state job loss as the reason for their homelessness (61 percent), and those classified as mentally ill were less likely to do so compared with participants in the total sample (51 percent). Participants classified as mentally ill or chemically dependent were also more likely to have been unemployed for a full 26 weeks prior to entering the program (50 and 45 percent were, respectively) compared with the total sample (38 percent). Also, people classified as mentally ill were among the hardest to place (they had a 26 percent placement rate), whereas those with alcohol abuse (39 percent placed) or drug abuse (38 percent placed) had rates higher than the overall rate of 34 percent.

The authors make the following recommendations to improve vocational training and job placement services for people who are homeless:

- Provide comprehensive and ongoing assessment to identify specific obstacles to employment that are not evident at the time of intake (e.g., substance use disorders, poor reading skills, a history of domestic abuse, mental health issues).
- Provide more ICM and longer-term support services for people who are homeless and have severe and prolonged mental illness, current or recent substance use disorders, or have been homeless for long periods.
- Provide an option for short-term job search and placement services for people who do not have access to financial benefits and housing assistance and who have an urgent need for income and housing. Also provide an array of support services to meet special needs of participants and offer access to longer-term occupational training/education once they have stabilized their situations.
- Provide follow-up services and ongoing case management (for at least 6 months after a job is secured) to troubleshoot problems and ensure that participants do not return to homelessness.

Vocational training services have been shown to improve behavioral health and other related outcomes, such as criminal behavior (see review in TIP 38, *Integrating Substance Abuse Treatment and Vocational Services* [CSAT, 2000a]). Depending on the severity and type of behavioral health disorder a client has, some specialized vocational services may be necessary. A meta-analytic review by Crowther, Marshall, Bond, and Huxley (2011), which was not limited to studies involving people who were homeless, found that for people with SMI, supported employment had a significantly greater effect in increasing participation in competitive employment than prevocational training, but both were associated with better outcomes than mental health services without a vocational component.

Kashner et al. (2002) showed that clients who were homeless and able and eager to work—when participating in a VA-compensated work therapy program that included mandatory substance abuse treatment and drug screening—participated more in other treatment services and had fewer substance use–related problems (including physical symptoms related to use), fewer episodes of homelessness and incarceration, and better physical functioning than did a control group of participants who were not participating in the work therapy program but had access to the same medical and psychiatric services .

In another VA study, Rosenheck and Mares (2007) compared two groups of clients with behavioral health disorders recruited from nine different VA programs for veterans who were homeless. The first group was recruited prior to implementing a supported employment program for clients; the second group was recruited from the same facilities after the supported employment program was implemented. Veterans who participated in the program had a mean of 15 percent more days of competitive employment during the 2-year follow-up period than did nonparticipants. Participants also had significantly more days in housing during follow-up than did nonparticipants.

Shaheen and Rio's (2006) career-mapping approach can help people who are homeless and seeking a job focus on the types of work for which they are prepared and which they are most interested in pursuing. Beck, Trutko, Isbell, Rothstein, and Barnow's (1997) guide will be of use to clinicians who are trying to help clients who are homeless obtain employment and develop employment-related skills. *Developing Community Employment Pathways* (Putnam et al., 2007) reviewed best practices for helping people who are homeless (regardless of their substance abuse histories) locate and obtain jobs and included examples from local programs around the country.

Help Obtaining Public Assistance

People with behavioral health disorders who are homeless may have an even harder time than other people who are homeless in accessing needed benefits, such as emergency income support or medical care. Public assistance in the form of disability-related monetary support is especially important, because it enables clients to pay rent for permanent supportive housing. HUD has produced a detailed guide titled *Strategies for Improving Homeless People's Access to Mainstream Benefits and Services* (Burt et al., 2010), which explains how to help people who are homeless overcome barriers and get public assistance and other benefits for which they qualify.

Many individuals who are homeless, including those with mental disorders, qualify for Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI). A detailed explanation of these benefits is beyond the scope of this literature review, but Rosen and Perret (2005) provide a guide for case managers who wish to help clients who are homeless obtain these benefits. The SSI/SSDI Outreach, Access, and Recovery program is an initiative designed to help people who are homeless and have mental disorders access benefits; the program is explained in detail in a publication available from Projects for Assistance in Transition From Homelessness (Kenney, 2008).

In a sample of 343 individuals who used two New York, NY, soup kitchens, Nwakeze, Magura, Rosenblum, and Joseph (2003) found that those who were homeless were less likely to access Medicaid and food stamp programs for which they were qualified than were domiciled

individuals. Although this study was not limited to people with behavioral health disorders, rates of substance use were high but comparable for the homeless and domiciled samples; self-reported histories of mental health treatment, while less frequent, were also comparable.

Bird et al. (2002) found the same level of need for public services in people who were homeless whether or not they had substance use disorders. However, those with substance use disorders (n=360), had significantly more trouble accessing the services they required than did those without substance use disorders (n=437). Participants with SMI were only significantly more likely than others to have contact with the mental health service sector if they did not have a co-occurring substance use disorder. Behavioral health service providers, therefore, will likely need to be strong advocates to help clients who have substance use disorders access the services and benefits they need.

Some clinicians are concerned that giving financial benefits to people who are homeless may result in increased substance use. Studies suggest that this is not the case and, in fact, clients who receive cash payments may have better outcomes on measures of housing and high-risk behaviors. Research on 2,474 veterans who had schizophrenia and a co-occurring substance use disorder found, after controlling for other factors, that those who received disability payments did not use substances on more days per month than those not receiving such payments (Frisman & Rosenheck, 2000).

Rosen, McMahon, Lin, and Rosenheck (2006) found that clients who were homeless with mental illness (N=6,199) and already received Social Security Administration (SSA) payments had somewhat more substance use (rated by clinicians) during the course of their study than clients who were not receiving SSA payments. However, there was no difference in the level of substance use between clients who started to receive SSA payments during the course of treatment and those who did not receive SSA benefits. In addition, there was also no significant increase in clients' substance use after they began to receive benefits. This study also found that the clients who began receiving SSA benefits during the study had significantly more days in housing but fewer days employed.

Cash payments through benefit programs were associated with fewer HIV/AIDS risk behaviors in an analysis of 1,156 people who were homeless (87 percent of the sample) or marginally housed, either with or without behavioral health disorders (Riley, Moss, Clark, Monk, & Bangsberg, 2005). Of subjects who were currently using injection drugs (22 percent of the sample), those who received cash benefits were 57 percent less likely to inject daily and 37 percent less likely to give or lend their needles to others.

Representative payeeship

Under representative payeeship, people receiving benefits are assigned a third party to handle disbursement of their disability funds, usually a treatment agency or a family member. Third-party money management is meant, in many cases, to limit inappropriate use of the funds. SSA data from the mid-1990s indicate that, of 2.2 million individuals who received SSI and/or SSDI disability benefits for a mental disorder, about 700,000 had been assigned representative payees (Rosen, McMahon, & Rosenheck, 2007).

Elbogen, Swanson, Swartz, and Wagner (2003) identified common characteristics among 102 third-party payee service recipients (not necessarily homeless) diagnosed with a psychotic or major affective disorder who had been involuntarily hospitalized in North Carolina between 1992 and 1996 and were awaiting discharge or outpatient commitment. Most of the patients with representative payees agreed they had enough money to cover necessities (e.g., food, clothing, transportation), but about half reported not having enough money for social or enjoyable activities. Given that treatment for both SMI and substance abuse emphasizes social skills and that isolation is considered a negative sign in treatment progress, clinicians should consider whether isolation is occurring as an exacerbation of symptoms or simply because the client does not have enough money to engage in social activity.

Research is limited on the impact of third-party payee services on clinical outcomes, and almost all of it has focused on clients with a primary diagnosis of a mental disorder. Rosenheck and Fontana (1994) studied a large sample of clients who were homeless with SMI entering CMHS's ACCESS program in 18 locations throughout the United States in 1993. The investigators found that assigning a payee without implementing additional dual-disorder approaches did not, in itself, improve substance use behaviors.

Ries, Short, Dyck, and Srebnik (2004) evaluated 44 clients (5 of whom were homeless) and found that incorporating representative payeeship into integrated behavioral health treatment was feasible and clinically useful for managing clients who had SMI and substance use disorders. Specifically, they looked at whether clients would demonstrate first-week-of-the-month increased substance abuse and hospitalizations, which have been shown in other studies (e.g., Halpern & Mechem, 2001; Herbst, Batki, Manfredi, & Jones, 1996; Phillips, Christenfeld, & Ryan, 1999). Evaluating each client for an average of 38.5 weeks, with little treatment or study dropout, Ries, Short, et al. (2004) found no evidence of a cyclic first-of-the-month pattern of substance use and hospitalizations in either the individuals diagnosed with schizophrenia and cocaine use disorders or the broader diagnostic sample.

In a larger study (N=1,457) of individuals with SMI who were receiving SSI or SSDI (a third of whom had histories of homelessness), after controlling for severity of substance abuse, Rosen, McMahon, and Rosenheck (2007) found that participants who had a representative payee did not have any greater reductions in substance use compared with those who did not have a representative payee, although the former did make more use of mental health services.

Mental Health Promotion

Although certain mental disorders may contribute to homelessness (see the "Behavioral Health Problems as Risk Factors for Homelessness" section), it is not always clear that such disorders precede homelessness, and, especially for youth, homelessness and other factors related to it (e.g., high incidence of trauma, loss of community, weakened social and family networks) may all contribute to the development of mental disorders (Cattan & Tilford, 2006).

Of the few published articles that address mental health promotion for people who are homeless, most address the needs of children and adolescents. Cattan and Tilford (2006) suggested that for younger people who are homeless, including young adults, mental health promotion activities that help create a sense of community and empower individuals may be particularly important.

Interventions to help prevent mental disorders in the children of families who are homeless include ones that improve parenting skills and reduce parental stress, such as multiple-family group interventions (Davey, 2004), and ones that provide early screening/assessment and brief treatment of children combined with advice to their parents (Tischler, Vostanis, Bellerby, & Cumella, 2002).

One area of mental health promotion addressed in some published literature is suicide prevention. People who are homeless have high rates of suicidal ideation and suicide attempts (Eynan et al., 2002; Prigerson et al., 2003). Childhood homelessness, being homeless for 6 months or more, and, for adults ages 55 and older, substance use disorders are all associated with higher rates of suicidality (Eynan, et al., 2002; Prigerson et al., 2003). More information on suicide prevention for clients in substance abuse treatment can be found in TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a).

Substance Abuse Prevention

The high rates of substance use disorders among people who are homeless are often assumed to contribute to homelessness (as discussed in the "Behavioral Health Problems as Risk Factors for Homelessness" section), but there are some indications that homelessness may increase some types of substance use and abuse. Regarding homelessness contributing to substance abuse, Johnson et al. (1997) found that becoming homeless and having lost a full-time job both increased the risk of showing symptoms of alcohol abuse.

Substance abuse prevention for youth who are homeless lies outside the scope of this TIP, but there is some information available on this topic (e.g., see the review by Sanabria, 2006). Little published information is available on substance abuse prevention for adults who are homeless, however. One exception is a preliminary study of the Power of YOU program intended for young adult women who are homeless, which seeks to prevent substance abuse along with HIV risk behaviors and interpersonal violence (Wenzel, D'Amico, Barnes, & Gilbert, 2009). According to focus groups conducted with program participants, the program was well received and was believed to be helpful by a majority of participants. In terms of substance abuse prevention, participants stated that the normative information about substance use among women who were homeless was useful and, for some, surprising, and a number of participants believed that the discussion of external and internal triggers for substance use would help reduce substance use.

HIV/AIDS Prevention and Treatment

Because of the elevated rates of HIV/AIDS in people who are homeless in general and in those who have substance use disorders in particular (see the "HIV/AIDS" section), addressing HIV/AIDS risk and providing testing are important services for this population. A substance abuse day treatment program with an HIV/AIDS education component was found to improve knowledge of HIV/AIDS significantly for clients who were homeless while also reducing HIV/AIDS risk behaviors (Lewis, Boyle, Lewis, & Evans, 2000). Providing housing for people who are HIV positive and homeless is, in itself, a means for potentially reducing the spread of HIV/AIDS. Both sexual and drug-related risk behaviors decrease when people who are homeless obtain housing (Aidala et al., 2005).

More information on treating clients with HIV/AIDS (regardless of their housing status) can be found in TIP 37, *Substance Abuse Treatment for Persons With HIV/AIDS* (CSAT, 2000c). Kushel and Miaskowski (2006) provided guidelines on how to work with clients who are HIV positive, homeless, and terminally ill.

Treatment Settings

People who are homeless and have behavioral health disorders may receive services in a variety of settings. Some services may be provided in settings specific to their circumstances, but most often, services are provided in standard mental health and substance abuse treatment settings.

Effective treatment planning is a prerequisite to success with any client. However, many clinicians experience formal treatment planning—mandated by accrediting and licensing organizations—as only tangentially applicable and therefore cumbersome to actual service delivery. An emerging alternative approach, "person-centered treatment planning" (Adams & Grieder, 2005), is distinguished by a practical focus on client goals in the context of how clients themselves define them. A full description of this approach is beyond the scope of this TIP.

As noted in the "Outreach" section, traditional service delivery channels might not be effective at reaching some segments of the homeless population. Treatment providers may need to take their services to the client. This sometimes requires actually implementing one's treatment program at a new site—a task that has been addressed creatively by many providers. For example, behavioral health treatment services have been successfully provided in soup kitchens (Kayman, Gordon, Rosenblum, & Magura, 2005; Rosenblum, Magura, Kayman, & Fong, 2005), homeless shelters (Bradford et al., 2005), mobile health clinics (Hastings, Zulman, & Wali, 2007), and emergency rooms (Witbeck et al., 2000).

Mental Health Treatment Settings

People who are homeless may receive mental health treatment in a variety of settings, although they are more frequent users of services provided in psychiatric hospitals and emergency departments than people who are domiciled, which is why those settings are highlighted here. Other facilities, such as community health centers (Lardiere, Jones, & Perez, 2011) and members of the Health Care for the Homeless Clinicians' Network, provide outpatient mental health services to this population. Although detailed placement guides for people with mental disorders who are homeless are not available, Healthcare for the Homeless has prepared short protocols for urgent (Norton, 2010b) and chronic mental health treatment (Norton, 2010a).

Psychiatric emergency settings

For reasons related to the severity of their disorders, lack of social support, and lack of access to other forms of care, people who are homeless use psychiatric emergency services much more frequently than do people who are housed (D'Amore et al., 2001; McNiel & Binder, 2005; Pasic et al., 2005). Such clients also often have medical comorbidities that need to be assessed and treated along with their behavioral health problems (Fishkind & Zeller, 2006).

Fishkind and Zeller (2006) discussed the treatment of people in these settings who are homeless and have mental illness, addressing methods of building the therapeutic alliance quickly with such clients by involving them in the decisionmaking process, using the least restrictive intervention possible, and trying to offer alternatives to hospitalization. They also noted the importance of providing follow-up care and case management to decrease further emergency visits.

Another aspect of psychiatric emergency settings for people who are homeless involves the use of mobile crisis teams, which can provide diagnosis, stabilization, and some treatment outside of medical facilities. Such teams are able to substantially reduce the need for psychiatric hospitalizations following crisis intervention (Guo, Biegel, Johnsen, & Dyches, 2001; Scott, 2000). Ng (2006) discussed working with people with mental disorders who are homeless using such teams and included a flowchart depicting decision processes involved in such services.

Psychiatric inpatient settings

People who are homeless use hospital services, including psychiatric inpatient services, at higher rates than people who are housed (Eyrich-Garg et al., 2008; Kushel, Vittinghoff, & Haas, 2001; Young et al., 2005). They are more likely to be hospitalized for mental health- or substance-related problems than those who are housed (Salit et al., 1998) and have longer hospital stays and higher costs associated with hospitalization even after adjusting for length of stay (Hwang, Weaver, Aubry, & Hoch, 2011; Salit et al., 1998). People who are homeless are also significantly more likely to return to psychiatric inpatient programs after release (Irmiter et al., 2007).

Nardacci (2006) reviewed issues in assessment, treatment planning, and discharge planning for people in psychiatric inpatient settings who are homeless. Discharge and continuing care planning is particularly important for clients who enter inpatient treatment when they are homeless, and options such as continuing day treatment/partial hospitalization, ACT, and court-mandated outpatient treatment/outpatient commitment (Swartz et al., 1999) should all be considered (Nardacci, 2006). Outpatient commitment, for example, has been associated with significant decreases in the risk of homelessness following discharge from psychiatric hospitals for people with SMI and severe functional impairment resulting from mental disorders (Compton et al., 2003). If available, CTI programs are another excellent option. Interventions such as CTI can help clients establish stable housing and prevent returns to psychiatric inpatient care.

Day treatment, or partial hospitalization, has been found effective for people with mental disorders who are chronically homeless. Shern et al. (2000) evaluated a day treatment psychiatric rehabilitation program for people with SMI who were living on the streets (i.e., not in shelters). The 2-year program was open 12 hours a day and offered food and daytime shelter in addition to optional treatment services and linkages to other services including shelter housing. At the end of the 2-year period, participants who received the intervention (n=91), compared with individuals in a control group who had access to standard services (n=77), were doing significantly better at meeting basic needs (e.g., being housed in shelters or community living, obtaining food and clothing, keeping clean), had significantly higher ratings in a number of areas related to quality of life, and had significantly lower levels of mental disorder symptoms.

For people who are homeless, another alternative is providing comprehensive services in a shelter. An example is Boston Medical Center's Advanced Clinical Capacity for Engagement,

Safety, and Services Project, which provides medical and behavioral health services to people with CODs in a "Safe Haven" shelter specifically designed for this use (see the description in Lincoln, Plachta-Elliott, & Espejo, 2009).

Yet another alternative to inpatient treatment for people with mental disorders who are homeless is supportive housing, which provides housing as well as a lower intensity of services. Supportive housing encompasses a range of levels and types of service (Corporation for Supportive Housing, 2006; HUD, 2001). (See the description in the "Supportive Housing" section.)

Substance Abuse Treatment Settings

Various substance abuse treatment services are available for people who are homeless, and (as noted in the "Prevalence of People Who Are Homeless in Behavioral Health Settings" section) members of this population use such services at higher rates than people who are housed. A few specific settings that incorporate housing and treatment are discussed here and in the "Supportive Housing" section. For clients with CODs, substance abuse treatment may also improve mental health. In a study of 95 people who were cocaine dependent and homeless, treatment participation was associated with significant reductions in mood and anxiety disorders (Kertesz, Madan, Wallace, Schumacher, & Milby, 2006).

Postdetoxification stabilization programs

People who are homeless have been found to be more likely to enter a detoxification program than people who are housed. According to 2009 TEDS data, 47.1 percent of treatment admissions for people who were homeless were to detoxification programs compared with 18.9 percent for people who had independent living arrangements (HHS, SAMHSA, OAS, 2011).

Stabilization programs are a critical component for preventing relapse after detoxification among people who are homeless. These short-term, transitional residential programs provide support for 2 to 6 weeks while clients obtain longer-term placement. People who were homeless and used a stabilization program had significantly lower rates of relapse 6 months after detoxification than did people who were housed or who were homeless and did not enter stabilization programs (Kertesz, Horton, Friedmann, Saits, & Samet, 2003). Detoxification services are discussed at greater length in TIP 45, *Detoxification and Substance Abuse Treatment* (CSAT, 2006a).

Inpatient and residential settings

People who are homeless are more likely to enter inpatient substance abuse treatment than those who are housed. According to 2009 TEDS data, 26.7 percent of people classified as homeless entered inpatient, nondetoxification treatment programs; only 13.8 percent of those classified as living independently did so (HHS, SAMHSA, OAS, 2011). Data from the Drug Evaluation Network System for 2003 and 2004, involving substance abuse treatment programs in 13 urban areas, show that people who had spent at least one night in a shelter or on the street in the month prior to entering treatment (and thus were considered homeless) were more than twice as likely as people with low incomes who were housed to enter inpatient/residential treatment (Eyrich-Garg et al., 2008). Wenzel et al. (2001) found that people who were homeless were more likely

to enter residential or inpatient treatment than outpatient treatment. Kertesz, Larson, et al. (2006) found that homelessness was associated with increased use of residential treatment services.

Little information is available comparing inpatient/residential and outpatient substance abuse treatment services for people who are homeless, but in a study in which people with SMI (i.e., schizophrenia and/or affective disorders) and co-occurring substance use disorders were randomly assigned to a residential treatment program (n=67) or an outpatient program with a similar design, retention rates were significantly higher for the residential program (Burnam et al., 1995). The authors also found better outcomes at an assessment 3 months after beginning the program for participants in the residential program, which they attributed to greater exposure to treatment, but most of those differences were not apparent at the 6- and 9-month assessments.

Modified therapeutic communities

One particular model of inpatient, long-term substance abuse treatment that has been adapted to meet the need of people who are homeless and have CODs is the modified therapeutic community (MTC), which exists in residential settings. Treatment is presented flexibly to accommodate differing levels of functioning. The core principles and methods of MTCs include engaging slowly into treatment, coping with stresses through personal responsibility and mutual help, using peers as role models and guides, acquiring skills to support vocational development and independent living, and developing healthy social skills and networks to sustain recovery (Sacks, Skinner, Sacks, & Peck, 2002).

MTCs have been adapted for women and children to provide family-style housing, daycare and after-school programs, a curriculum focusing on parenting issues for mothers, and modifications of the daily program routine to accommodate parenting responsibilities (Sacks, Sacks, Harle, & De Leon, 1999). Short-term MTCs have also been implemented within homeless shelters, and their use was associated with significant decreases in substance use, criminal behavior, and depressive symptoms (Liberty et al., 1998).

In research with populations of people who were homeless and those who were housed, participation in MTCs has been associated with increased employment and decreased substance abuse, criminal activity, and symptoms of depression (De Leon, Sacks, Staines, & McKendrick, 2000). Nuttbrock, Rahav, Rivera, Ng-Mak, and Link (1998) compared outcomes for people with CODs who were homeless and who received treatment at an MTC with those for people with CODs living in community residences while attending treatment. Both interventions led to improvements in clients' substance use and psychopathology. However, those in the MTC generally showed more significant improvements. They were more likely to achieve and maintain sobriety, had greater reductions in symptoms of depression and anxiety, and scored better on a measure of general functioning.

Mierlak et al. (1998) reported that 34 percent of a sample of men at an MTC who were homeless and had CODs stayed in treatment for the prescribed length of stay. Dropping out of treatment was associated with more serious mental disorders (demonstrated by more frequent past hospitalizations) and a worse employment history.

De Leon et al. (2000) compared two different types of MTC programs and a treatment-as-usual control group (involving a variety of treatment options) for clients who were homeless. The second MTC program involved more freedom for clients, participation outside the TC at a day treatment program, reduced client responsibilities related to program operations, and more direct assistance to clients from staff. The researchers found that clients in both MTC groups had significantly better outcomes for substance use, criminal activity, HIV/AIDS risk behaviors, and psychological dysfunction than did individuals in the control group at 1 and 2 years after assessment, with the second MTC model providing the best outcomes.

Egelko et al. (2002) found that an MTC approach for people who were homeless with CODs produced significant improvements in all measured psychological symptoms between intake and third-month reassessment (midway through the program), with more subtle improvements seen in a smaller number of subjects at the end of treatment.

Sacks, De Leon, Sacks, McKendrick, & Brown (2003) used a TC model to develop a supported-housing unit for continuing care following treatment in an MTC program for people who were homeless and diagnosed with CODs. Those who entered TC-oriented supportive housing had better outcomes than clients in other housing options for substance use, crime, and attendance at mutual-help meetings.

MTC treatment costs no more than usual care approaches (French, Sacks, De Leon, Staines, & McKendrick, 1999; McGeary, French, Sacks, McKendrick, & De Leon, 2000). French, McCollister, Sacks, McKendrick, and De Leon (2002) estimated and compared the economic benefits and costs of MTC treatment for a group of clients who were mentally ill, homeless, and abused substances with a "treatment-as-usual" comparison group. Data from the 12-month period before MTC admission were compared with data from the 12 months after admission across three outcome categories: employment, criminal activity, and use of healthcare services. The economic cost of the average MTC treatment episode was $20,361. The economic benefit generated by the average MTC client was $305,273. The incremental economic benefit per MTC client (relative to treatment as usual) was $273,698, resulting in a net benefit per MTC client of $253,337 and a benefit–cost ratio of 13:1. The incremental economic benefit estimate, after adjustment for extreme outlier observations, was $105,618, the net benefit was $85,257, and the benefit–cost ratio was 5:2.

See TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c), for more information on the MTC model.

Behavioral day treatment with abstinence-contingent housing and work therapy

Milby et al. (1996) designed a 6-month intervention for individuals who had alcohol and drug use disorders that combined behavioral day treatment and abstinence-contingent housing (ACH), which they called BDT+. The intervention had two phases. Phase I (2 months) consisted of behavioral day treatment and therapeutic goal management for substance use disorders. Homelessness was addressed by providing transportation, meals, and program-provided ACH. These interventions obtained urine samples at least weekly to monitor abstinence and did not rely on counselor suspicion of relapse. Phase II (4 months) consisted of ACH, therapeutic management of housing goals to foster housing independence, and contingency-managed work

therapy with continuing care group sessions. The wages paid for 25 hours of work per week were used to lease the clients' housing. After work, clients were encouraged to attend continuing care groups. For the control group, usual care (UC) consisted of twice-weekly individual and group counseling sessions that were 12-Step oriented. Clients were referred for housing and vocational services available in the community. UC was provided with no specified endpoint. Less frequent continuing care visits for counseling and support were provided as needed.

At the end of both phases, clients in ACH had fewer cocaine-positive urine toxicology tests, with regression toward baseline at 12 months. From baseline to the end of 12 months, these clients had fewer days of reported alcohol use, homelessness, and unemployment. UC clients showed no significant changes except a temporary increase in employment at 6 months. The largest between-group differences and effect sizes were found for reductions in alcohol use and homelessness. Clients with high attendance (2 to 6.63 contacts per week) demonstrated significantly fewer days of alcohol use in the past 30 days and significantly fewer cocaine-positive urine screens, days of homelessness, and days unemployed over 12 months compared with other clients (Schumacher et al., 1995).

The positive results for alcohol and cocaine abstinence and reduction in homelessness led to a series of studies to determine how to improve retention and abstinence. The first enhancement was to include a modest voucher system to provide exposure to reinforcers unrelated to drugs, which became the new control condition (Milby, Schumacher, McNamara, Wallace, & Usdan, 2000). The experimental group combined this enhanced behavioral day treatment with ACH and abstinence-contingent work. Treatment phases were the same as in the earlier study. Participants were homeless and cocaine dependent with nonpsychotic CODs. Clients in the combined treatment demonstrated greater treatment retention, significantly more days abstinent, and significantly more consecutive weeks abstinent by the end of both phases. At the end of Phase II, these clients also had significantly more days housed. There were no significant differences in percentage of days employed between groups. The combined treatment had the greatest effect on sustained abstinence. Clients with high rates of attendance in both BDT+ and the control group had a higher average number of consecutive weeks abstinent. A significant treatment effect remained after accounting for increased attendance between groups. This finding suggests that ACH and work contribute significantly to the observed treatment effect. The presence of one or more nonpsychotic Axis I disorders, in addition to cocaine dependence, made no difference in abstinence, housing, or employment outcomes relative to people who had no additional Axis I disorders (McNamara et al., 2001).

This intervention was replicated in a pilot project in Houston, TX (Milby & Schumacher, 2008), where BDT+ was compared with an inpatient intervention for 1 month followed by 5 months of an outpatient intervention similar to BDT+ (consisting of weekly continuing care, job development, and housing assistance) but without ACH. Participants were randomly assigned individuals who had been diagnosed with cocaine dependence and co-occurring nonpsychotic mental disorders. At 1- and 2-month follow-up, significantly more BDT+ clients had negative urine toxicology test results for all drugs. These results show that contingency-managed housing and behavioral day treatment can be transferred to new providers with beneficial results. Group-by-time interaction was significant, suggesting that BDT+ initially increases days homeless during treatment (as the contingency is applied) but reduces homelessness over time (Milby &

Schumacher, 2008). BDT+ can be implemented more easily in urban clinical settings where core components of contingency-managed behavioral day treatment already exist.

To examine whether housing without an abstinence contingency (non-abstinent-contingent housing [NACH]) plus effective day treatment would be sufficient for improved outcomes, Milby, Schumacher, Wallace, Freedman, & Vuchinich (2005) compared NACH (n=67), ACH (n=63), and a control group that received no housing (NH) (n=66). All three conditions received all other elements of the day treatment. Participants had cocaine dependence and co-occurring nonpsychotic mental disorders and were randomly assigned. Intention-to-treat analyses suggest that ACH increased abstinence compared with NACH and produced an even greater increase compared with NH. Because the NACH clients had more incentive for attendance—in that there were no negative consequences for drug-positive urine tests—their attendance was higher than that of ACH and NH groups. When the contribution of attendance to abstinence was controlled, however, only ACH produced greater abstinence than NH.

Milby et al. (2008) compared ACH plus work therapy but no behavioral day treatment (CM) (n=103) with ACH plus work therapy and behavioral day treatment (CM+) (n=103). Interventions lasted 6 months. The CM+ group had slightly but consistently more days of abstinence in each period of 24 weeks of active treatment and many more days of abstinence at 12 and 18 months. The findings suggest a potentially robust therapeutic impact with a much less complex abstinence-contingent intervention. The impact of behavioral day treatment as measured in the CM+ group was delayed and observed as more sustained abstinence at long-term follow-up. The two groups did not differ in terms of housing and employment outcomes, although consecutive weeks of abstinence during treatment were significantly related to increased housing and employment stability (Milby et al., 2010). Additional analysis found that the CM+ group had significantly fewer PTSD symptoms than those in CM (Lester et al., 2007).

Two points must be emphasized regarding the results presented in this section. First, these researchers imposed ACH as a treatment element only when secure shelter was available to persons who were removed from housing. Removal to the streets with no follow-up (common in many community programs) was not part of this model. Second, clients removed from ACH were invited to continue in the outpatient treatment program even after removal from housing. Moreover, return to abstinence—demonstrated with 1 week of negative (clean) urine drug screens—permitted immediate return to program-provided housing.

Housing

Housing is the cornerstone of recovery for people with behavioral health disorders who are homeless. Still, research on housing remains formative, and methodology in most housing studies has yielded less-than-optimal clarity regarding which housing models work best (Fakhoury, Murray, Shepherd, & Priebe, 2002; Rog, 2004).

Stable housing can, depending on the type of housing provided, have an effect in reducing substance use, symptoms of mental disorders, need for psychiatric emergency services and psychiatric hospitalizations, and vulnerability to other problems for people who are homeless (see reviews by Kyle & Dunn, 2008; Leff et al., 2009; McMurray-Avila et al., 1999). For clients with schizophrenia, housing is associated with better adherence to medication regimens (Gilmer

et al., 2004). Providing housing to clients who are in substance abuse treatment is associated with improved outcomes relating to longer-term housing (Kertesz et al., 2007), employment (Kertesz et al., 2007), and substance disorders (Buchholz et al., 2010; Mares, Kasprow, & Rosenheck, 2004; Milby et al., 2005). Housing is also a more significant factor than case management or other services in preventing future homelessness for people with mental illness (Schutt et al., 2009). Giving clients with behavioral health disorders a choice when it comes to housing is associated with improved quality of life (O'Connell, Rosenheck, Kasprow, & Frisman, 2006).

According to a review by Kyle and Dunn (2008), there is good support for providing housing to people with SMI who were formerly homeless to reduce rehospitalizations; there is also some, albeit weaker, evidence that housing is associated with improvements in mental status. In another review, Leff et al. (2009) concluded that both permanent supportive housing and residential care and treatment were associated with significant reductions in alcohol and drug abuse.

Providing housing before engaging a person who is homeless into behavioral health programs improves motivation for treatment. Erickson et al. (1995) found that stable housing at the time of entry into substance abuse treatment increased willingness for treatment; employment or current level of substance use at entry had no effect on willingness in clients who were homeless.

However, providing behavioral health services by themselves is not sufficient to help people who are chronically homeless obtain and maintain stable housing. Meschede (2010) followed 174 people who were chronically homeless (82 percent of whom had a major disability resulting from a mental disorder and 94 percent of whom had a substance use disorder) for a 3-year period and found no significant relationship between the extent of use of either medical or substance abuse treatment services and obtaining housing, whereas greater use of detoxification services was negatively related to obtaining housing.

Models of housing for people who are homeless and have substance use disorders (Hannigan & Wagner, 2003) include the following:

- Sober or dry housing, which has a strict abstinence policy and where substance use results in termination of housing.
- Damp housing, where people both with and without substance abuse problems live together, abstinence is not monitored but illicit substances are prohibited, alcohol use in public spaces is disallowed, and treatment services are sometimes provided.
- Wet housing, which uses a "harm-reduction" model that refers clients to substance abuse treatment services but does not require any participation and allows alcohol use (although typically not illicit substance use) on the premises.

Supportive Housing

Supportive housing (also known as "supported" housing) is low- or no-cost independent housing with additional services or supports. People who qualify for supportive housing are homeless and have some mental disorder, disability, or chronic health condition. According to HUD's (2001) *Supportive Housing Program Desk Guide*, supportive housing encompasses transitional housing, permanent housing for persons with disabilities, and safe-haven programs (which can be either permanent or transitional). CMHS has published a guide to implementing permanent supportive housing (also available online) as part of its *Evidence-Based Practices: Knowledge Informing*

Transformation series (SAMHSA, 2010). The Corporation for Supportive Housing (2006) offers the *Toolkit for Developing and Operating Supportive Housing* as well as *Developing the "Support" in Supportive Housing* (Hannigan & Wagner, 2003) to sustain the provision of behavioral health treatment services in supportive housing programs and to provide other useful information pertaining to developing, funding, and administering supportive housing programs.

Reviewing the research on supportive housing, Rog (2004) found strong evidence for a positive effect on housing outcomes, somewhat less evidence for a greater effect on housing compared with other models, and preliminary evidence on the cost-effectiveness of supportive housing compared with other models. A review by Nelson, Aubry, and Lafrance (2007), which looked at studies of ACT and ICM in addition to supportive housing, found that, for people with SMI, supportive housing was associated with the largest effect sizes for housing stability outcomes.

One version of supportive housing includes the provision of "cafeteria-style" services, allowing clients to choose the aspects of treatment they wish to receive while providing them with immediate, independent housing. This version appears to produce better long-term housing outcomes than the traditional model of mandatory treatment followed by referral to permanent housing for people who are homeless and have SMI. In research on a New York, NY, program of this type, 88 percent of the participants with mental disorders who had been homeless before entering supportive housing (n=241) remained housed after 5 years compared with only 47 percent of similar clients in the traditional care system (n=1,600) (Tsemberis & Eisenberg, 2000).

Rosenheck, Kasprow, Frisman, and Liu-Mares (2003) evaluated veterans who were homeless and diagnosed with behavioral health disorders and who were randomly assigned to one of three groups, all of whom received supportive housing, with the addition of Section 8 vouchers and ICM services (n=182), ICM added to standard VA services (n=90), or standard VA services alone (n=188). They found that the supportive housing intervention produced better outcomes related to housing but not related to symptoms of mental illness, substance abuse, or community adjustment. However, a reanalysis of the data from this study, which used multiple imputation methods to account for missing data, found that participants had significantly better outcomes in terms of days of drinking, days of drinking to intoxication, days of drug use, and drug-related problems (measured with the Addiction Severity Index) (Cheng, Lin, Kasprow, & Rosenheck, 2007).

Mares, Kasprow, and Rosenheck (2004) found that veterans who were homeless, diagnosed with CODs, and received treatment before entering supportive housing did not have better housing- or employment-related outcomes than those who entered supportive housing without having received treatment in the prior 6 months. However, in another analysis of data from the VA-supported housing program, O'Connell, Kasprow, and Rosenheck (2009) compared outcomes for 979 participants who were directly placed into supportive housing and 460 who were first placed in residential treatment programs. They found that participants who were placed in residential treatment prior to entering supportive housing had significantly more severe substance use/abuse, less social support, and lower ratings of quality of life on entering the program than those who entered supportive housing directly. The former also had significantly more improvements in these areas over the course of 2 years in the program; by the end of that period, differences between the two groups (except in the area of employment) were no longer significant.

More data on supportive housing came from 734 participants in the Federal Collaborative Initiative to Help End Chronic Homelessness (CICH), who received supportive housing that included substance abuse treatment, medical care, and mental health treatment (Mares & Rosenheck, 2010). At an assessment 1 year after entry into the study, participants showed significant improvements in mental disorder symptoms (according to Brief Symptom Inventory scores) and housing outcomes but not in substance abuse outcomes.

Cost estimates

The *Corporation for Supportive Housing Chart Book Report* (Lewin Group, 2004) presents cost estimates for serving people who are homeless in six different settings: supportive housing, jails, prisons, shelters, mental hospitals, and general hospitals (Exhibit B). These estimates of the average cost of providing 1 day of service to a person in each setting were meant to capture the underlying cost of providing services as opposed to the payments received from public payers. Supportive housing was defined as housing that combined building features and personal services to enable people to live in the community as long as they were able and so chose.

In an analysis of people who were homeless and had behavioral health disorders in long-term supportive housing, Martinez and Burt (2006) compared service use during the 2 years before entry into supportive housing with service use during the 2 years after entry. They found that the majority of residents made less use of emergency medical services and were less likely to require hospitalization after entering long-term supportive housing. Supportive housing alone (without a substance abuse treatment component) reduced costs associated with medical services among individuals with SMI who were homeless (Culhane et al., 2002). In CICH, participants also had significant decreases in healthcare costs (a decline of 51 percent during 1 year of supportive housing) (Mares & Rosenheck, 2010).

Rosenheck (2010) provided a cost-effectiveness acceptability curve based on data from a VA-supported housing evaluation (Rosenheck et al., 2003) that demonstrates how incremental

Exhibit B: Range of Estimated Service Costs Per Day by Setting	
Supportive housing	$20.54 (Phoenix, AZ) to $42.10 (San Francisco, CA)
Jail	$45.84 (Phoenix, AZ) to $164.57 (New York, NY)
Prison	$47.49 (Atlanta, GA) to $117.08 (Boston, MA)
Shelter	$11.00 (Atlanta, GA) to $54.42 (New York, NY)
Mental hospital	$280 (Phoenix, AZ) to $1,278 (San Francisco, CA)
Hospital	$1,185 (New York, NY) to $2,184 (Seattle, WA)

Range established across Atlanta, GA; Boston, MA; Chicago, IL; Columbus, OH; Los Angeles, CA; New York, NY; Phoenix, AZ; San Francisco, CA; and Seattle, WA.

Source: Lewin Group, 2004.

increases in costs for supportive housing relate to the probability of the interventions being cost-effective, showing, for example, that benefits have an 80 percent chance of outweighing costs if $75 per day are spent on supportive housing.

Poulin, Maguire, Metraux, and Culhane (2010) evaluated 3 years of service use and cost data for 2,703 people who were homeless. They found that 20 percent of their sample (56 percent of whom had SMI and a history of substance abuse treatment and 25 percent of whom had SMI without a history of substance abuse treatment) accounted for 60 percent of the total service costs. Forty percent of the participants, who were the most likely to have a history of substance abuse treatment without an SMI diagnosis, accounted for only 8 percent of total costs. The authors concluded that providing supportive housing for the majority of people who are homeless will not result in cost savings and that lower intensity interventions addressing substance abuse combined with rental assistance should be considered for the many people who are homeless.

Another large study (Culhane, Metraux, & Hadley, 2002) compared service use rates and costs for 4,679 people with SMI who were homeless in New York, NY, and placed in supportive housing with rates and costs for matched control subjects who were homeless but not placed in housing. Marked reductions in shelter use, hospitalization, length of stay per hospitalization, and time incarcerated were observed for those in supportive housing. Placement was associated with a reduction in service use costs of $16,281 per year; annual costs of each housing unit were estimated at $17,277. The net per-person cost of realizing substantial improvements in health and well-being for those who are homeless was estimated at $995 per year (housing unit cost minus service-cost offset) in the first 2 years after housing placement.

Housing First

Under the Housing First approach, people who are chronically homeless and have severe, chronic mental health and/or substance use disorders are placed in independent permanent housing before being engaged into treatment. Based on clinical observations, many clients who enter Housing First programs are not able to engage in traditional behavioral health services until they have stabilized their situations and built relationships with providers (Foster, LeFauve, Kresky-Wolff, & Richards, 2010). Providing housing increases willingness for treatment (Erickson et al., 1995). By offering housing and choices about treatment, Housing First programs build a sense of mastery in otherwise disenfranchised clients (Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005) and improve quality of life and community integration for participants (Gulcur, Tsemberis, Stefancic, & Greenwood, 2007).

However, critics of Housing First programs note that they may not be suitable for people with severe substance abuse disorders and caution that the presence of people actively using substances in housing units may have a detrimental effect on other residents who are trying to maintain recovery (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009).

Housing First programs typically have high rates of housing retention. For example, a HUD-sponsored study by Pearson, Montgomery, and Locke (2009) of 80 people with SMI and CODs found that 84 percent were still enrolled 1 year later, with half of those individuals having spent every night in the program's housing. Similarly, a study that compared two Housing First

programs and a standard control group for 260 individuals with SMI who were long-term users of shelter services found that individuals were more likely to obtain stable housing in the Housing First programs and that, at 2 years into the study, 84 percent of clients in Housing First were stably housed (Stefancic & Tsemberis, 2007).

In Housing First programs, supportive services are generally available 24 hours a day, 7 days a week, to help clients stay in their housing. This approach produces better long-term housing outcomes for this population than traditional models of mandatory treatment followed by referral to permanent housing. For example, in a comparison of traditionally accessed supportive housing based on perceived "housing readiness" with a Housing First program combining scattered-site housing and ACT team services, 88 percent of 240 people (all with mental disorders and half with CODs) receiving Housing First remained housed after 5 years compared with 47 percent of those in the traditional care system (n=1,600) (Tsemberis & Eisenberg, 2000).

Tsemberis et al. (2004) compared a Housing First option with housing that was contingent on entering treatment and remaining abstinent for people who were homeless and diagnosed with CODs. Participants in the Housing First program entered stable housing significantly faster and had more days in stable housing. There were no significant differences in the level of substance use between participants in the two programs, but the group in the enforced abstinence program did attend more treatment sessions. Padgett, Gulcur, and Tsemberis (2006) compared outcomes from a Housing First program and a "treatment first" program serving people who were homeless and diagnosed with CODs. They found individuals in the Housing First program had significantly better housing outcomes but found no significant differences on outcome measures of alcohol and drug use at 48 months (Padgett et al., 2006). In another study of 95 participants enrolled for 1 year in a Housing First program, Larimer et al. (2009) tracked regular decreases in drinks per day (from a median of 15.7 at baseline to 10.6 at 1 year) and in days spent drinking to intoxication (from a median of 28 out of 30 at baseline to 10 out of 30 at 1 year) for individuals with severe alcohol use disorders, but changes did not rise to the level of significance, and problems with self-reported data may have confounded results.

Another study, which compared Housing First (n=99) with a Continuum of Care program that had treatment and sobriety requirements for housing for clients with SMI (recruited from either psychiatric hospitals or through street outreach), found that Housing First was associated with significantly greater reductions in rehospitalization for those recruited from hospitals and significantly more days in housing for those who had been living on the streets (Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003). Overall service costs were also significantly lower for Housing First participants.

For clients with SMI, Housing First participation has also been associated with significant decreases in mental disorder symptoms severity (Greenwood et al., 2005). In their comparison of Housing First and treatment as usual for people with SMI, Greenwood et al. (2005) examined mediating factors. In addition to having better housing outcomes, they found that participants in Housing First had significantly fewer symptoms of mental illness and significantly better ratings of perceived choice, that perceived choice significantly affected decreases in symptoms, and that perceptions of personal control partially mediated this relationship. The authors theorized that Housing First approaches increase sense of personal control and sense of having choices, which in turn improve mental health.

On the other hand, some researchers have found no significant changes in substance use or mental disorder symptom severity associated with participation in Housing First programs (Pearson et al., 2009); others have found no significant differences from control groups following participation in Housing First programs (Padgett et al., 2006; Sadowski, Kee, VanderWeele, & Buchanan, 2009; Tsemberis, Gulcur, & Nakae, 2004;). Kertesz et al. (2009) cautioned that, in their review of Housing First studies, they were unable to identify programs that included people with severe substance use disorders and that many of the studies (including some of those mentioned here) did not use rigorous methods to assess substance use (e.g., relied on self-report).

Stefancic and Tsemberis's (2007) research compared two Housing First programs. One provider, Pathways to Housing, was new to the suburban county where the study was conducted; the other provider was a newly formed consortium of local treatment and housing agencies that had no experience in Housing First programming. After 4 years, Pathways to Housing retained 78 percent of people in housing; the consortium retained 57 percent. Pearson et al. (2009) also found large differences in nights spent in housing between the programs they evaluated, which they attributed to differences in occupancy rules.

Pearson, Locke, Montgomery, Buron, and McDonald (2007) examined small samples of people who were chronically homeless, diagnosed with long-standing mental illnesses and (in most cases) CODs, and enrolled in one of three different Housing First programs. More than 50 percent of participants at all three sites had psychotic mental illness. Histories of substance abuse were common, but the severity of substance abuse was not assessed, and only 40 percent of participants had ever sought substance abuse treatment. The study demonstrated substantial housing stability and enrollment into services for participants. Over 12 months, 62 percent of participants in the program using ACT team services and scattered-site housing, 40 percent of participants using multidisciplinary treatment teams and congregate living, and 28 percent of participants using multidisciplinary intensive clinical case management teams and scattered-site housing were continuously housed with no temporary departures.

Larimer et al. (2009) found that costs associated with a Housing First program decreased significantly over the first 12 months in the program (from a median of $4,066 per person in month 1 to $1,492 in month 6 to $958 in month 12) for a group of people with severe alcohol problems and significant healthcare problems who were chronically homeless (*n*=95).

An analysis of mental health costs for a San Diego Housing First program for people with SMI who were homeless found that participation was associated with an average decrease in hospital costs of $6,103 and a decrease of $570 in costs for mental health services provided through the criminal justice system. These costs were largely offset by an increase of $6,403 for case management services (Gilmer, Manning, & Ettner, 2009).

Housing First issues related to veterans will be discussed in the planned TIP, *Reintegration-Related Behavioral Health Issues in Veterans and Military Families* (SAMHSA, planned h).

Cost Recovery and Cost-Effectiveness of Behavioral Health Services

The costs of implementing a particular strategy for addressing homelessness are an obvious consideration as a community formulates its plans. As might be expected, given the complexities

of the issues, information on costs in the published literature is neither plentiful nor clear-cut. This section discusses two related issues. The first is cost recovery—the return in terms of reduced healthcare and social service costs when behavioral health services are offered to people who are homeless. The second is cost-effectiveness—comparisons of outcomes of interventions with different costs. There is growing evidence that providing treatment and related services to people who are homeless can substantially reduce costs of healthcare and other services. The cost-effectiveness of specific types of interventions, such as supportive housing, has been discussed in preceding sections of this literature review, as has the cost-effectiveness of specific interventions and models.

Salit, Kuhn, Hartz, Vu, & Mosso (1998) compared New York, NY, hospital discharge data on 18,864 admissions of persons who were homeless with data from 383,986 admissions of other low-income patients. Lengths of hospital stay for people who were homeless (adjusted for principal diagnosis, coexisting illness, and demographics) averaged 36 percent longer than in a housed, low-income sample. Costs of additional hospital days for those who were homeless averaged $4,094 for mental health patients, $3,370 for HIV/AIDS patients, and $2,414 for all types of patients. The vast majority of hospitalized people who were homeless had principal or coexisting diagnoses of substance use or mental disorders; nearly three quarters were hospitalized for conditions for which hospitalization is often preventable. The authors noted that costs of services for people who are homeless should be considered in light of potential offsets in hospital care costs. For example, in New York, NY, 70 days of subacute hospital mental health treatment costs almost 30 percent more than 1 year of supportive housing with social services.

Smaller studies of people with substance use disorders who are homeless support these results regarding cost recovery. Dunford et al. (2006) demonstrated significant cost offsets in emergency medical services, emergency department use, and inpatient services for 156 people who were homeless and chronically inebriated who accepted treatment in San Diego, CA. Similar results were obtained for ethnic- and gender-specific supportive housing and intensive street case management provided to 92 people who were chronically inebriated (60 percent of whom were Native American) in Minneapolis, MN (Thornquist, Biros, Olander, & Sterner, 2002). A pilot study identified people who were homeless, chronically abused substances, and used emergency services frequently and offered them intensive community-based case management (Witbeck et al., 2000). Ten people who were enrolled in the program showed large decreases in use of the emergency room compared with eight people who were not enrolled.

A randomized study of costs and outcomes of interventions for people with substance use disorders who were homeless compared the cost-effectiveness of four drug treatment interventions (Schumacher, Mennemeyer, Milby, Wallace, & Nolan, 2002). One study component compared groups randomly assigned to a standard care condition (12-Step–based counseling and continuing care) or to an enhanced condition (day treatment, continuing care, ACH, and abstinence-contingent work therapy for minimum wage). A second study component compared groups randomly assigned to the same enhanced condition (day treatment, ACH, and abstinence-contingent work therapy for minimum wage) or to a standard day treatment condition (day treatment, continuing care, and vocational rehabilitation). The main outcome variable was days of abstinence at 2-, 6-, and 12-month follow-up. For both components, enhanced treatment cost over twice as much as standard treatment. Although enhanced treatment produced better outcomes at earlier points in time, these differences disappeared by the 12-month follow-up. The

average cost per week of abstinence favored the less expensive standard treatments in all but one comparison. However, the average incremental cost per week of abstinence was not large for the enhanced treatments. The authors concluded that policymakers should consider enhanced treatments that reduce homelessness (e.g., include ACH) because the incremental costs are reasonable and can lead to positive outcomes not measured in this study.

Stecher, Andrews, McDonald, and Morton (1994) found that although daily operating costs were 35 to 45 percent higher for residential services, the cost associated with successful treatment completion was about the same for either residential or outpatient settings.

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