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TREATMENT FOR THE HOMELESS MENTALLY ILL

MASTERS OF ARTS THESIS

OF

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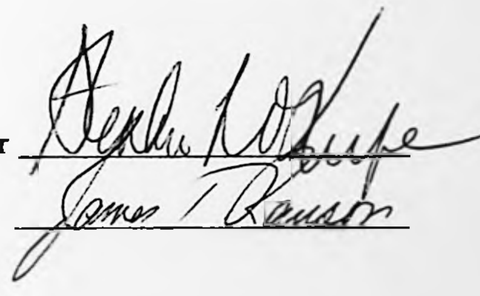

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Abstract

The effect of treatment on the homeless mentally ill was explored. Seventeen homeless individuals were screened with questionnaires to determine anxiety and depression (Krug, Laughlin, Scheiner, & Catell, 1976). One group included diagnosed mentally ill subjects, the other were non-diagnosed individuals. Both groups were tested upon admittance to either a treatment facility for homeless mentally ill persons or a community homeless shelter, respectively. They were again screened prior to discharge of either facility. Statistically, a rather significant difference was noted in the decrease of the diagnosed group's anxiety level upon discharge. A similar, but less significant, statistical difference was also noted in the diagnosed group's depression upon discharge, when they were compared to the non-diagnosed group. Clinically, these differences are important in that 40% of the diagnosed group's anxiety was decreased, as was 30% of the individuals' depression.

Acknowledgments

I would like to thank my family for their patience and understanding, especially you, Ben. Dr. O'Keefe, I am definitely taking this time to make sure I thank you for your editing and wonderful teaching abilities; you gave the "other school's reject" a chance... and now they can stick it where the sun don't shine. Finally, to Dr. Lawhon who has stuck by me for the last two years and agreed with me every time I said, "I am going to finish". Guess what, Dr. Lawhon, "I'm finished"!

"The vast majority of homeless people are, by anyone's definition, mentally ill"

-Philip Terzian

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TREATMENT OF THE HOMELESS MENTALLY ILL

Although extensive research on the homeless mentally ill population has been conducted, existing studies have failed to answer what kinds of services should be offered and what kind of services are most successful. Successful service planning must address the full array of disabilities experienced by the homeless, including psychiatric symptoms and lack of social opportunities. The early 1990s were a sponsor to the National Institute of Mental Health's projects that tested the effectiveness of different housing, support, and rehabilitative services in reducing homelessness (Shern, Felton, Hough, & Lehman, 1997). These services included: a range of acceptable housing alternatives, case management, psychiatric treatment, and rehabilitative services. They found that these strategies are effective in engaging and stably housing homeless individuals with severe mental illness.

The most prominent viewpoint within psychology conceptualizes that the fundamental problem of homeless mentally ill people is their mental illness. This viewpoint rests on the notion that homelessness among the mentally ill stems from the disabled functioning of their disorders. Homeless mentally ill people have complex needs and require a broad array of resources, such as housing, mental health and substance abuse treatment, health care, and income supports and entitlements (Randolph, Blasinsky, Leginski, Parker, & Goldman, 1997).

The homeless crisis of the last two decades has focused on housing as a mental health issue. It is currently regarded that providing places to live is a crucial element in providing services for the severely mentally ill. The housing needs of the mentally ill vary considerably, and finding homes with the necessary range of support services and supervision is a major challenge. In addition to service fragmentation and inefficiency, communities also lack or have a low supply of critical resources and services such as

affordable housing and assertive outreach and case management services to the homeless mentally ill population (Randolph et al., 1997).

The access of the homeless mentally ill to the benefits of psychiatric treatment has been limited by a shortage of public-sector psychiatric beds and a tendency to regard the homeless mentally ill as untreatable. Housing opportunities for severely the mentally ill need to be of quality and appropriateness for such a population's functioning. With regard to the adjustment of persons with severe mental illness to community life, there has been an agreement that individual needs and competencies must match supportive community environments.

Those who work with homeless people are likely to encounter a broad spectrum of mental disorders and as with any other patient population, clinical interventions must be guided by specific biological, psychological, and social needs. However, for individuals who are both homeless and suffer from psychiatric disabilities, effective approaches may require significant modifications of traditional techniques and changes in specific interventions. Services to the homeless mentally ill need to include more broadly based social casework services that stress basic needs and goal attainment. Emergency shelters have become the backbone of service delivery to the homeless mentally ill. Many residents of such above mentioned facilities develop coping strategies that provide them with a feeling of mastery unparalleled on the outside.

There is a certain segment of the homeless population that may never gain sufficient trust and a sense of psychological security to move away from the streets to a residence operated by organized parties. Here lies a need for a specially designed living environment that allows for personal freedom, active engagement and treatment, and adequate housing. Service may be directed toward physical exams, health care, dental care, clothing, dietary needs, psychotropic medications, psychiatric rehabilitation

programs, housing planning, and/or financial planning. The goal of such a service providing facility is to assist the consumer in gaining the necessary skills and resources that will enable them to move into permanent housing in the community of their choice.

The purpose of this study is to evaluate the success ratio of clients entering and leaving a shelter for the homeless mentally ill, and proceed into independent community living. Evaluations will determine if the implementation of such a facility is an asset to community support services and the homeless population. There are two hypotheses proposed by this researcher. The first hypothesis is that homeless individual's IPAT anxiety scores will be lower after treatment than before. The second prediction is that homeless individual's IPAT depression scores will also lower with treatment.

Method

Subjects

The total number of subjects was 17. There were two groups, one consisting of 10 adults, and the other consisting of 7adults. One group consisted of adults with a mental illness diagnosis. The second group consisted of adults who have no history of a mental illness diagnosis. The group with a "diagnosis" were identified by their medical records. The Diagnostic and Statistical Manual, 4th ed. (DSM-IV) lists the criterion for the diagnoses (American Psychiatric Association, 1994). All of the diagnosed subjects were taking medications upon admittance, with approximately 80% receiving medication changes during their stay. The non-diagnosed subjects were at no time medicated. All of the subjects were homeless, with the diagnosed group staying in a treatment facility for the homeless mentally ill, and the non-diagnosed group staying in a non-treatment oriented homeless shelter.

Procedure

The author of this study administered the test in a manner consistent with the instructions given by Krug, Scheiner, Laughlin, & Catell (1976). Subjects were given exactly the same standardized instructions.

A testing booklet for the depression exam was handed to each subject. Test instructions were printed on the front page of the testing booklets. As permitted by the manual, the author chose to read the instructions aloud to increase clarity. The author emphasized that all questions were to be answered directly on the booklet and reminded each subject of their anonymity. The exams were turned into the author upon completion. The exact same method was utilized for the anxiety exam. It was administered after all subjects had completed the depression exam.

The exams were then scored by the author, with standardized instructions from the testing manuals. The scores of diagnosed subjects were then compared to the scores of non-diagnosed subjects.

Instruments

The instruments used in this study were the I-PAT Anxiety and Depression Scales. The I-PAT Scales were designed as a means of getting clinical information is a quick, objective, and non-stressful manner. The scales give an accurate assessment and are designed as supplements to other clinical evaluations and procedures.

Reliability estimates are available for the I-PAT Scales, and the Scales have been stable over intervals when the score is most likely to be used (Krug et al., 1976). A test-retest coefficient has been reported of .6-.7. Using the relationship between reliability and standard error of measurement, the tests' standard errors of measurement are approximately three raw score points. In other words, about two-thirds of the time, an individual's true score will fall within three points of their raw score.

The validity of the I-PAT Scales was approached from factor-analytic investigations, studies of clinically assessed anxiety and depression, and other measures of anxiety and depression (Krug et al., 1976). All these factors considered, and assuming the average reliability of other measures is close to the I-PAT's .70, the extent to which the scales measure the anxiety and depression concepts approaches .90.

Results

The Analysis of Variance (ANOVA) and Analysis of Covariance (ANCOVA) were used in significance testing. Both tests were used to assess differences between pre and post tests, and differences between diagnosed and non-diagnosed individuals. The hypothesis of this study was that mentally ill diagnosed homeless individuals would score lower on anxiety and depression scales, upon discharge from a psychiatric treatment facility, than their counterparts discharged from a community-based homeless shelter.

The ANOVA found that there was no significant difference among the groups. There were no notable differences on anxiety or depression tests for either diagnosed or non-diagnosed individuals.

The ANCOVA judges post-tests based on pre-test performance. The ANCOVA is a more stringent analysis and conservative procedure than the ANOVA. The ANCOVA controls the individual's pre-treatment level and allows for the individual to be their own control.

When the subjects' anxiety predicting pre-test was used as the covariant, the ANCOVA found a difference between the diagnosed and non-diagnosed groups with anxiety. That is, the diagnosed group had a significantly lower level of anxiety, upon discharge, than the non-diagnosed group. The diagnosed group's adjusted mean score was 48.09, with a standard deviation of 8.24. The non-diagnosed group's adjusted mean score was 38.30, with a standard deviation of 10.69.

A very small difference was noted in depression with the diagnosed group when the ANCOVA was applied. The diagnosed group's adjusted mean score was 50.26, with

a standard deviation of 5.59. The non-diagnosed group's adjusted mean score was 44.91, with a standard deviation of 11.24.

Statistically, placement of a homeless person in a treatment facility lowers their anxiety test scores. The same statistical significance is true of the person's depression test scores.

Discussion

Clinically speaking, these numbers represent the following information regarding treatment for the homeless mentally ill. When judging anxiety, 40% of the diagnosed individuals raised their score, upon discharge, at least one standard deviation higher at discharge than at admittance. As far as clinical judgement assessing pathology, none of the subjects' anxiety raised above a point where they would not be considered anxious, as compared to being diagnosed as anxious upon admittance.

Depression scores were assessed much the same way, and concluded 30% of the diagnosed individuals scored at least one standard deviation higher upon discharge than when they were admitted. Unfortunately, pathology cannot be dismissed here either, as none of the subjects' scores raised high enough to clinically judge depression as in remission or alleviated.

One final treatment effect might be related to the fact that 80% of the diagnosed individuals were medicated when admitted to the treatment facility and all were medicated upon discharge. Considering none of the non-diagnosed individuals were medicated, medication is a weighted factor, but with the difference among groups being no more than shown, medication would only have a slight baring on this study.

The homeless population's need for treatment in regards to housing alternatives, case management, psychiatric treatment, and rehabilitative services, was shown in previous research by Shern et al. (1997). These needs were supported by the results of this study, which showed improvement in anxiety and depression for the homeless severely mentally ill, after treatment in a treatment/care facility.

One limitation of this study was the number of subjects. A larger number of subjects may have supported the hypothesis that admittance to a psychiatric treatment facility for the homeless lowers anxiety and depression. Another limitation of this study was that the motivation of the subjects was not considered. All of the mentally ill diagnosed subjects were medicated at the time of the test administration, which may have effected true emotional responses.

This study seems to indicate that it is somewhat beneficial to place a homeless mentally ill person in an in-patient facility for treatment until they can be successful at community living. Susser, Goldfinger, & White (1990) suggested effective treatment for this above mentioned group may require significant changes and must be accessible to those usually rejected by the mental health system, while Baker and Douglas' (1990) found quality and adequacy of housing effects community adjustment outcomes. Studies agree that mental dysfunctioning is a major contributor to homelessness, while indisputable amounts of literature reveal there is a definite need for specialized rehabilitation for the homeless mentally ill.

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Table 1

Anxiety post test scores for diagnosed versus non-diagnosed (N = 17).

Source Value	DF	Type III SS	Mean Square	F-Ratio	PR>F
Group	1	362.35	362.35	26.40	.0002
Covariant	1	1104.49	1104.49	80.48	.0001
Error	14	192.12			
Corrected Total	16	2182.94			

Table 2

Depression post-test scores for diagnosed versus non-diagnosed (N = 17).

Source Value	DF	Type III SS	Mean Square	F-Ratio	PR>F
Group	1	96.15	96.15	1.98	0.18
Covariant	1	356.88	356.88	7.33	0.02
Error	14	681.44	48.67		
Corrected Total	16	1434.94			

APPENDIX A

Literature Review

Homeless mentally ill individuals do not fit neatly into existing housing programs, which often have stringent acceptance criteria. There is a need for placement and maintenance of the seriously mentally ill into housing. The success of such a program is contingent on the availability of adequate housing options and ensuring that homeless mentally ill people have a choice of how and where they wish to live their lives. Almost all the literature on the subject agrees with the proposal that an enormous percentage of homeless individuals are mentally ill, and there is a definite lacking of resources for those who are both homeless and mentally ill. According to Shern, Fetton, Hough, & Lehman (1997), the early 1990s were a sponsor to the National Institute of Mental Health's project's that tested the effectiveness of different housing, support, and rehabilitation services in reducing homelessness. Shern's et. al (1997) findings indicate that effective strategies are available for serving homeless individuals with mental illness.

Bassuk and Rubin (1984) interviewed seventy-eight homeless people living in an emergency shelter to find over 90% had a mental illness diagnosis. They suggested homeless shelters have been a source of care for these individuals otherwise rejected by the mental health system. Bachrach (1992) looks at the failure of homeless studies to include prevalence, the result of deinstitutionalization, and the type of services needed to improve the success rate of the homeless mentally ill. Randolph, Blasinsky, Leginski, Parker, & Goldman (1997) conclude that homeless mentally ill people have complex needs and require a broad array of resources, such as housing, mental health and substance abuse treatment, health care, and income supports and entitlements. Bachrach also suggested increasing future research on these needs and issues, along with attempts

for service planning, dedicated response to needs, and an increase in societal opportunity for the homeless mentally ill population. Coincidentally, Belcher and DiBlasio found a high incidence of depression with low self-esteem, no food, poor family relations, lack of goals, poor health, and substance abuse; suggestions were made for more intense case management and assistance with goal achievement. Likewise, Susser, Goldfinger, & White (1990) found the homeless population is comprised of several mental disorders and residential patterns. Effective treatment for this population may require significant changes from traditional therapeutic techniques. Susser et al suggested a successful provider of treatment would be accessible to those usually rejected by the mental health system, would link and refer them to community living, and would obtain knowledge about the success of social housing. There is also a tendency of shelter-based homeless to decrease in interpersonal skills, hygiene, and independent abilities as a coping skill for street life; this tendency can be largely reduced, by assisting the homeless with positive socialization and therapeutic intervention (Grunberg & Eagle, 1990). Randolph et. al (1997) found that in addition to service fragmentation and inefficiency, communities also lack or have a low supply of critical resources and services, such as affordable housing and assertive outreach and case management services.

More and more authors, and their studies agree that mental disfunctioning is a major contributor to homelessness, with the main deficits including disorganized thoughts, depression, immobilization, lack of problem-solving skills, and paranoia. Other contributing factors include an ineffective mental health care system, dual diagnoses of substance abuse, and irrationalizations. Lamb and Lamb (1990) suggested a more intensive assessment of younger homeless individuals and a highly structured living situation, including support, protection, treatment, and rehabilitation. This problem does not only affect individuals; groups of homeless and low-income housed families were

studied and an overwhelming majority had severely depressed heads of households or heads of households suffering from Post Traumatic Stress Disorder. Thirty percent of these heads had attempted suicide, statistically speaking, three times as many as the general population. And, the crisis does not stop in the United States, 30-50% of Britain's homeless population is represented by the mentally ill (Scott, 1993).

Childhood physical and sexual abuse also correlates significantly with homelessness and severe mental illness. Results from Davies-Netzley, Haurlburt, & Hough's (1997) study showed a prevalence of childhood abuse was substantially higher for homeless women. The abuse experience was related to an increase in suicidality and symptoms of posttraumatic stress disorder for these women. Davies- Nutzley's et al. (1997) findings suggest that childhood abuse is an important precursor to homelessness for many women with chronic and severe mental illness.

Morrissey, Calloway, Johnson, and Ullman (1997) surveyed representatives from 18 sites where programs for homeless persons with serious mental illnesses were instated. Results from their study concluded services for people who are mentally ill and homeless are fragmented, not readily assessable, and in dire need of improvement. Baker and Douglas (1990) examined the appropriateness necessary for successful community living of 729 deinstitutionalized psychiatric patients. Evidence suggested quality and adequacy of housing affects community adjustment outcomes. While investigating the effects of linking inpatient schizophrenics to outpatient care, Olfson, Mechnic, Boyer, & Hansell (1998) found the period immediately after psychiatric discharge is especially hazardous, and patients are at an increased risk for homelessness. An alternative option was reported by Benett, Gudeman, Jenkins, Brown, and Benett (1988) on a program devised to increase access of homeless mentally ill patients to hospital-based treatment; the program demonstrated success of this treatment for this population. Olfson et al.

(1998) also agree that outpatient care shows a trend toward reduced homelessness. Breakey and Fischer (1995) discussed the homeless crisis with attention focused on housing as a mental health issue. They indicated state appropriate living quarters are crucial in providing successful service to the homeless mentally ill. The main conflicting idea in perceptions and needs of the homeless mentally ill population is the likelihood providers would only identify a need for mental health services, whereas clients also seek medical, dental, and employment assistance (Rosenheck & Lam 1997).

Alisky and Iczkowski (1990) researched the idea of a lack in public housing affecting the success of recently discharged psychiatric patients and leading to such a high rate of homelessness among these people. Twenty-two percent of the landlords contacted in the Alisky et al. study refused to rent to a diagnosed client, even though a credible statement was given by a mental health professional verifying the client's stabilization, non-violent behavior, maintenance on medication, and financial ability. This on-going discrimination appears to be a contributing factor in the rise of the often publicly intolerable homeless population. Caton, Wyatt, Grunberg, and Felix (1990) reported the results of a follow-up experiment determining success of a mental health program for homeless mentally ill men. Their reports found success with placing these men back into the community and were undeniable.

Indisputable amounts of literature reveal the same idea: there is a need for specialized rehabilitation for the homeless mentally ill. There are 600,000 to 700,000 homeless people in the United States alone, with well over half of these people suffering from some type of mental dysfunction. Statistics like these can not be ignored; a successful program needs to be established in order to assist this population. The purpose of this study is to evaluate one such facility's success.

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