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Housing Homeless Who are Diagnosed with Mental Illness: Social Service
Professionals' Perspectives

by
Kayla Sprenger

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work

St. Catherine University and the University of St. Thomas
St. Paul, Minnesota

In Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Housing the homeless who are diagnosed with a mental illness has been a problem for decades, not only for the individual, but society as a whole. In this study, eight social service professionals in the Minneapolis/St. Paul area who work with homeless individuals diagnosed with a mental illness were interviewed. A qualitative approach, incorporating a semi-standardized survey was used. Content analysis was used to analyze the data. This study obtained data for the purposes of understanding the social service professionals' perspective of how housing the homeless with a mental illness is beneficial. The survey included questions regarding changes in mental and physical health symptoms, crimes committed, use of services, goals, safety and what is needed to maintain housing. There are many barriers for those who are diagnosed with a mental illness to obtain and maintain their housing. It is imperative for social workers to meet the individual where they are at in their recovery process and to advocate for and assist with identifying and reducing barriers. Emphasis should be placed on the housing first approach and social workers should advocate for more affordable housing.

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Introduction

Imagine having no bed, no food to eat, feeling alone, and not knowing where to turn to stay safe. Those are the realities for an estimated 744,000 people in the United States who are homeless on any given night, and about 40-45% of them have a serious mental illness (Nichols, 2008). Mental illness does not discriminate; in fact it affects every one in four people in a given year (National Alliance on Mental Illness, 2014). Housing the homeless who are diagnosed with a mental illness is an issue that all social service professionals should be aware of now more than ever. The amount of homeless people diagnosed with a mental illness is drastically increasing. In 1994, only 20% of homeless were diagnosed with a mental illness in Minnesota; however, that statistic rose to 40-50% in 2009 (Wilder Research, 2010).

When someone becomes homeless, it can affect many parts of their lives and society as a whole. For people with a serious and persistent mental illness, receiving some support in maintaining their housing can make all the difference. The state of Minnesota has defined the criteria for serious and persistent mental illness (SPMI) as follows: an adult with a diagnosis of schizophrenia, bipolar disorder, major depression or borderline personality disorder, two or more episodes of inpatient care within 24 months, continuous psychiatric hospitalization or residential treatment exceeding six months duration, or court commitment as a mentally ill person under chapter 253B in the last three years (Minnesota Department of Human Services, 2014). The five SPMI diagnoses are listed below.

- “Schizophrenia is a mental disorder that makes it hard to: tell the difference between what is real and not real, think clearly, have normal emotional responses, act normally in social situations” (A.D.A.M Medical Encyclopedia, 2014, p.1).

- “Bipolar disorder is a condition in which a person has periods of depression and periods of being extremely happy or being cross or irritable. The person also has extreme changes in activity and energy levels” (A.D.A.M. Medical Encyclopedia, 2014, p. 1).
- “Major depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with daily life for weeks or longer” (A.D.A.M. Medical Encyclopedia, 2014, p. 1).
- “Borderline personality disorder (BPD) is a mental health condition in which a person has long-term patterns of unstable or turbulent emotions. These inner experiences often result in impulsive actions and chaotic relationships with other people” (A.D.A.M. Medical Encyclopedia, 2014, p. 1).

Serious and persistent mental illness can affect people’s ability to conduct essential aspects of daily living, such as self-care, maintaining a job, and household management. Having a mental illness may also prevent people from obtaining and maintaining stable relationships and may cause them to react irrationally. This often results in pushing away caregivers, family, and friends who may be the ones who were keeping that person from becoming homeless (Solutions Center, 2014).

The Department of Housing Urban Development (HUD) has created an extensive definition of homeless that reads “an individual or family who lacks a regular, fixed, stable nighttime residence including a place not meant for human habitation”. Also, “an individual or family at imminent risk of losing housing, individual or family fleeing domestic violence, and unaccompanied youth 25 or younger and families who don’t qualify under the HUD definition, but qualify as homeless under other federal statutes” (Kelly, 2011, p.1). Two main things have

been identified as the underlying causes of homelessness; a shortage of affordable rental housing and an increase in poverty.

Housing is unaffordable for many who live with serious and persistent mental illness. For housing to be considered affordable, the household would pay no more than 30 percent of their annual income. If costs exceed this limit, individuals may have difficulty paying for necessities such as food, clothing, transportation, and medical care (Housing Urban Development, 2013). “The average Supplemental Security Income (SSI) payment in 2008 was almost 30 percent below the federal poverty level for a one-person household” (National Alliance on Mental Illness, 2014, p 1).

The National Coalition for the Homeless reported a 32% increase in home foreclosures between April 2008 and April 2009. Since the start of the recession, 6 million jobs have been lost (National Coalition for the Homeless, 2009), causing more people to fall under the poverty line. HUD reports that there is a shortage of affordable housing for those who have very low incomes. About 200,000 rental housing units are destroyed annually. As the cost of rent is continuing to increase, the income of people who are in poverty is continuing to decrease (National Coalition for the Homeless, 2009). More rental subsidies are needed, as only about one third of poor renter households receive one (Daskal, 1998). The waiting list for Section 8 housing vouchers can be several years long, which results in people being homeless or needing to stay in shelters longer. Also, recession and foreclosures have flooded the rental market. With this demand for renting, vouchers that are available are not being accepted as easily now that landlords are able to be more selective. Overall, the availability of affordable rental units has decreased because demand is allowing rental prices to increase.

Homelessness has been an issue for hundreds of years and will likely always be an issue. It is a matter of how prevalent the problem will be. Starting as far back as 1640, homelessness was seen as a moral deficiency or a character flaw. An individual or family would need to prove themselves to the community fathers in order to get a place to stay (Downtown Congregations to End Homelessness, 2011). Still today, many people think that homeless individuals can easily stop being homeless by proving themselves in society and getting a job or some other funding support. In the 1970's when de-institutionalization started, there was a large increase in homeless individuals who were diagnosed with a mental illness. People in the social service industry were trying to reduce the population size of mental institutions by shortening hospital stays, releasing patients that would be able to live in another location such as a group home or in the community, and reduce admission and readmission rates. "This continuing process of deinstitutionalization without adequate alternative resources led the mentally ill into homelessness, jails, and self-medication through the use of drugs or alcohol" (Bentley, 1994 p. 8). There was a greater increase in community based care such as group homes, assisted living, and halfway houses to try to provide proper care for these individuals.

The focus on housing for the homeless who are diagnosed with a mental illness has shifted once again. Today in Minnesota, the Olmstead Plan is in place to help people with disabilities to live, learn, work, and enjoy life in the most integrated setting possible. Many people who are diagnosed with a mental illness are currently living in group homes, halfway houses, assisted living and supportive housing programs. The goal is for people who are diagnosed with a mental illness to live in the community and as independently as they choose. According to the Olmstead Plan "people with disabilities will choose where they live, with whom, and in what type of housing" (Olmstead Subcabinet, 2013, p. 10). The steps that the

Department of Human Services and Minnesota Housing Finance Agency will take to carry out this plan are to identify people with disabilities who want to move to more integrated housing and identify the barriers involved, increase the amount of affordable housing, increase housing options that promote choice, increase access to information about housing options, and promote and encourage providers to implement best-practices and person centered strategies related to housing (Olmstead Subcabinet, 2013). Unfortunately, the goal to have those who are diagnosed with a mental illness choose where they want to live may increase homelessness. For example, those who are being discharged from a more intensive care setting too soon will not have the proper services set up to assist with their success with housing and such individuals may not be able to maintain a lease for long periods of time.

More choices and the push to live independently may decrease the amount of halfway houses, foster care settings, and board and care lodges. Halfway houses are meant for reintegration of persons who have been recently released from jail or a mental institution (Piat, 2000, p. 1). There are two types of foster care - Family Adult Foster Care and Corporate Adult Foster Care. "Family Adult Foster Care is an adult foster care home licensed by the Minnesota Department of Human Services. It is the home of the license holder and the license holder is the primary caregiver" (Minnesota Department of Human Services, 2014, p 1). "Corporate Adult Foster Care is an adult foster care home licensed by the Minnesota Department of Human Services. The license holder does not live in the home and is not the primary caregiver. Instead, trained and hired staff generally provide services" (Minnesota Department of Human Services, 2014, p 1). Typically, staff are available 24/7 and are trained to work with those who are diagnosed with a mental illness. Board and care lodges provide sleeping accommodations and meals to five or more adults for one week or more. They have private or shared rooms with

supportive services such as housekeeping, laundry, or personal care services (National Alliance on Mental Illness, 2013).

Supportive housing is a combination of housing and services intended as a cost-effective way to help people live more stable, productive lives for those who are diagnosed with a mental illness. “Supportive housing is widely believed to work well for those who face the most complex challenges” (Public Housing Authorities, 2008, p. 1). Supportive housing services started in the mid-1970’s when states were starting to realize that people with a serious mental illness were having difficulty with obtaining and maintaining their housing. Many states started out with transitional group homes and apartments. Residents in these programs were expected to attend service programs and also move as they made progress in their rehabilitation. These residents were receiving the support they needed to stay housed; however, they were having to move to a new place every time they made progress towards their rehabilitation. Once the states figured out that this was a problem, they started supportive housing programs. Having supportive housing programs gives people with a mental illness permanent housing options with services that are designed to meet each individual’s needs (Sullivan, & Cuomo, 2012). Culhane, et al. (2002) and Martinez et al. (2006) found that individuals who participate in supported housing programs commonly reduce their use of certain services that are frequently used by individuals who are homeless, such as emergency department, sobering services, jail and hospital care.

Incarceration for the homeless who are diagnosed with a mental illness is a common problem. “Nearly one million adults with a serious mental illness are booked into jails annually, and many of these individuals have histories of homelessness” (Morissey, et al., 2007). According to Padgett, et al., (2006), among people who were homeless and then incarcerated, 75% of them showed symptoms indicating the presence of mental illness (p. 76). Studies have

shown that the incarcerations of those who are homeless and have a mental illness are generally short-term and involve crimes like disturbing the peace or loitering. Lack of proper medications and psychiatric care often increases psychiatric symptoms, which may cause someone to do things that they wouldn't normally do, thus increasing their chance of incarceration.

Another widespread problem for those who are homeless and have a mental illness is substance use. In some cases, substance use can cause homelessness, but what some people don't realize is that being homeless can also cause substance use. According to Substance Abuse and Mental Health Services (2011), in 2010 on a given night, 34.7% of all sheltered adults who were homeless had chronic substance use issues and 26.2% had a severe mental illness (p. 2). People who are homeless often turn to drugs to gain temporary relief from their problems. People who have mental health symptoms often use substances to alleviate their symptoms, particularly if they do not have adequate access to healthcare or healthcare insurance in order to obtain appropriate medications or therapies. This substance use can cause addictions for such individuals, with their priorities of paying bills and rent slipping away. For many people who are homeless, survival is most important and going to mental health or chemical dependency treatment may be put on the back burner or may not be an option due to financial barriers as other basic needs take precedence. A bigger priority is often finding food and shelter.

There are a variety of supports that people with a mental illness may qualify for, such as supportive housing, case management, independent living services, assertive community treatment teams, adult rehabilitation mental health services, chemical dependency treatment, and vocational support. According to The National Alliance on Mental Illness (NAMI) (2014), "Without treatment, the consequences of mental illness for the individual and society are

staggering. The economic cost of untreated mental illness is more than 100 billion dollars each year in the United States” (p. 1).

This paper reviews housing with supports for individuals who are diagnosed with a serious and persistent mental illness and are homeless. There is a lot of research out there that focuses on one or two factors related to homelessness; however, this study is more broad and inclusive and is able to focus on how the lack of stable housing affects the whole person diagnosed with a mental illness and not just some small aspect of their lives.

Additionally, the perspectives of social service professionals in the Minneapolis/St. Paul area who have worked with homeless individuals who are diagnosed with a serious and persistent mental illness were obtained. These individuals were asked questions to gather information of their perspectives of how homelessness affects those who are diagnosed with a mental illness. Housing with supports for those diagnosed with a mental illness reduces costs, improves mental and physical health, and reduces crime rates.

Literature Review

Housing people with a mental illness with supports is beneficial to the individual and society in many ways. The purpose of this literature review was to review literature regarding the individual and societal benefits of housing people with a mental illness with supports. The literature review is broken down into the following categories: role of services provided, cost effectiveness of housing, mental and physical health, substance use, incarceration, and stigma.

Role of Services Provided

Maintaining housing for those with a mental illness can be extremely difficult, especially for someone who has been chronically homeless. According to NAMI (2014), the most successful approach for helping those who are homeless with a mental illness is the “housing

first” approach. This approach provides permanent housing followed by voluntary supportive services. With the housing first approach, there are no conditions for readiness, such as sobriety. There may be many barriers that get in the way of maintaining housing, such as lack of independent living skills, using substances, lack of money and resources, and structured activities and supports. However, according to the Federal Task Force on Homelessness and Severe Mental Illness (1992), the evidence shows that most people who have been diagnosed with a serious mental illness can live independently in the community with appropriate housing and supportive services that are put in place to meet their needs.

There is a wide variety of services that can be put in place to help someone with mental illness to maintain their housing, it really just depends on that individual’s needs. Hurlburt, Wood, and Hough (1998), studied 362 people with schizophrenia, major depression, or bi-polar disorder. Subjects also had to be homeless or in jeopardy of losing their housing. The program gave them each a Section 8 voucher with case management services and tested if there was a correlation between giving them a voucher and maintaining housing as well as giving them case management and maintaining housing. This study found that there was no correlation between case management and people maintaining their housing; however, there was a correlation between people having a Section 8 voucher and being able to maintain their housing long-term. Those who were given a Section 8 voucher were 7.56% more likely to follow a stable independent housing pattern than those without one (Hurlburt, Wood, & Hough, 1998). However, the study excluded participants who could be a danger to themselves or others and those who had previous criminal activity. Certain types of populations may benefit more from case management or other services.

Min (2002), examined if case management had a role in ending homelessness. In this study, the sample size was 475 homeless individuals with 279 of them having case management or other therapeutic services compared to the others who did not. Min tested how many times they were in and out of homelessness, and their linkage to other services. Those who had supportive services, on average, had a slower rate of shelter use, faster rate of shelter exit, and a shorter stay in the shelter. Also, Min found that when individuals were linked with independent living services, they were more likely to maintain housing, as they were learning skills to live independently; however, this study was only a year long and may have had different outcomes if the participants were studied for a longer period of time.

An exploratory study commissioned by HUD (2009) studied three separate housing programs. The three housing programs were Pathways, DESC, and REACH. All of the supportive housing programs had supports and believed in the Housing First model; however, Reach required people to have supports and some of the landlords that REACH leased with had strict lease requirements prohibiting drug or alcohol use. Out of the three, REACH experienced more housing instability. Even though this was a Housing First program, many of the places that they leased to required them to have supports and strict lease requirements. The other two programs had supports, but they were optional if individuals wanted to use them. It is hard to say if there was a relation in making people have supports, or if it was because of other causes that REACH was the least likely to keep people housed. It is important to remember that just because someone lost their housing with these housing programs, they were still likely to continue working with the client to help them find stable housing elsewhere. The immediate advantage of the Housing First approach for the chronically homeless population is that direct placement in housing solves the problem of homelessness (Pearson, Montgomery, & Locke 2009).

A study by McBride (2012), took 11 participants who were diagnosed with a mental illness and were homeless and did a phenomenological study, which is a study of different ways in which people experience something or think about something. She found that the homeless population had plenty of services that were available to them, however, they had barriers to receiving the services. She also found that many of them were struggling with getting affordable healthcare and transportation was an issue. If individuals had services such as case management or independent living services they could assist or refer them to get their needs met more effectively. As this research has shown, services may or may not be effective in keeping someone housed depending on the individual's needs.

Cost Effectiveness of Housing

Many agencies found that housing the homeless is cost effective (United States Interagency Council on Homelessness, 2013, National Alliance to End Homelessness, 2007, National Alliance on Mental Illness, 2014). People with a mental illness can have many physical and mental health problems that increase the amount spent on hospitalizations. Also as noted above, many homeless people are committing crimes to survive, which results in jail and may cost taxpayers more money. According to National Alliance to End Homelessness (2015), "hospitalization, medical treatment, incarceration, police intervention, and emergency shelter expenses can add up quickly, making homelessness surprisingly expensive for municipalities and taxpayers."

Numerous studies have found housing the homeless to be cost-effective. The Australian Housing and Urban Research Institute did a study on the cost-effectiveness of homelessness programs in 2008. They found that supportive housing programs produced positive outcomes for clients immediately when the individual came into the program at low costs. "The supportive

housing programs result in a significant potential net government cost savings from providing assistance” (Flatau, et al., 2008, p. 258). In all of the programs they examined, they found that even if the programs achieve less than one-half of the potential benefits, they would still be cost neutral, compared to the homeless individual remaining on the streets (Flatau, et al., 2008). In another study, Moulton (2013) examined whether programs that provide services to homeless people can reduce chronic homelessness. Moulton combined homeless counts and funding from HUD and included community fixed effects to come up with his data. Moulton estimated the effect of funding for specific types of homeless programs on the rate of chronic homelessness, and found that increasing funding for long-term homeless programs for people with disabilities would reduce chronic homelessness (Moulton, 2013). In these two studies, findings show that if funding for supportive housing programs is increased, this will decrease homelessness and be cost-effective. Both studies agreed that supportive housing programs are more cost-effective than paying for the costs of those that are homeless. A study by McLaughlin (2010) analyzed the service usage of 268 homeless individuals who were diagnosed with a mental illness in rural and urban communities. McLaughlin analyzed the costs six months before these individuals had housing and then in six-month increments after they had housing. Costs included healthcare, mental health care, community support, substance abuse treatment, prescribed drugs, ambulance use, police contact, jail night stay, shelter night stay, and emergency room visits. McLaughlin found that before individuals had housing, the overall cost was \$18,629 for services. After housing was provided, services were estimated at \$12,704, and housing at \$4,577 in a six-month time frame. The cost of services for providing safe, stable housing was more than \$1,000 less per person for a six-month time frame than having them remain on the street. Healthcare costs before individuals were housed were estimated at \$846,806.69 and after six months of having housing,

the total dropped to \$645,884.78. After one year of housing, the cost of healthcare dropped even further to \$540,0978.82. According to this study, “when people are placed in supportive housing environments they become stable and utilize fewer services than when they were homeless” (McLaughlin, 2010, p. 409).

According to Bazelon (2008) with the Center of Mental Health Law, people with mental illness often lose access to Medicare, Medicaid, and Social Security benefits. Reapplying for benefits can be time consuming and complex. Without case management assistance to reapply for benefits, prisoners reentering the community are at risk of recidivating or requiring costly emergency medical services. This can be especially problematic as homeless individuals with a mental illness often have more medical health issues. One study at a hospital in Chicago, Illinois studied 407 homeless adults with a chronic medical illness. They offered them transitional housing followed by long-term housing with case management. They found that, on average, after 18 months of long-term housing with case management, the participants had half the hospitalizations, 2.7 times fewer hospital days, and 1.2 times fewer emergency department visits (Sadowski, Kee, VanderWeele, & Buchanan, 2009). The amount of money that a hospital stay can cost taxpayers can be outrageous. This study shows that when people are housed with supports, their hospitalizations were significantly reduced, leading to a significant cost savings.

Mental and Physical Health

People who have a mental illness are more likely to have co-occurring physical health conditions, resulting in higher health care costs and disability (Scott et al, 2009). One fourth of the homeless population lack needed medical care (National Alliance to End Homelessness, 2012). Since physical and mental health can often go hand in hand, they will be discussed together.

Supportive housing programs are associated with increased access to health care and improved health outcomes. A 40-month longitudinal study of supportive housing conducted by Nelson and Laurier (2010) studied individuals with a mental illness who were formerly hospitalized and then transitioned into a supportive housing program in the community. “The members of the lodge showed significant improvement over time in terms of reduced hospitalizations and increased competitive work” (Nelson & Laurier, 2010, p. 129). The article went on to say how supportive housing programs are associated with many positive health outcomes for people with serious mental illness (Nelson & Laurier, 2010). Additionally, Kertesz et al. (2010), at UAB School of Medicine and School of Public Health in Birmingham, specifically studied the use of health care among homeless in 2009. They surveyed 200 individuals at four local homeless shelters. The report found that many homeless individuals believed their lack of access to healthcare “stands in the way of obtaining a job and housing” (Kertesz et al., p. 1). Many respondents stated that since becoming homeless, they have needed help with medications (70%), seeing a dentist (62%), and receiving general medical care (77%) (Kertesz, et al., p. 1). Additionally, people who were homeless reported they were not receiving help with their physical health in shelters or on the street and that they were more worried about finding a safe place to stay than keeping up with their physical health.

Consequently, the health benefits of supportive housing may be somewhat dependent on the individual. An analysis was done using the homeless management information system and surveys of local supportive housing programs, by Smith (2011), for the city of Birmingham. Smith found that with supportive housing, “health was improved by greater access to medical and psychiatric care” (p. 63), as well as an increased stability in the lives of participants with improved relationships, increased incomes, improved coping skills, and an increase in obtained

identification documents. Unfortunately, these benefits were not seen in individuals with a criminal history related to their physical and mental health. Similarly, a study by Casper and Clark (2004) specifically looked at service utilization and hospitalizations of clients in supportive housing programs for 56 individuals with a mental illness. The findings found that “a history of incarceration was associated with more 911 calls and other incidents, but not hospitalizations” (p.183). Residents with a criminal history did not achieve positive outcomes from supportive housing, but those without criminal histories did (Casper & Clark, 2004). Housing programs need to be altered to fit the needs of each individual in the program.

Speaking from experience with working with individuals who have a mental illness, I have observed many of them can have an increase in mental health symptoms for a variety of reasons. A study done by Fichter (2006), housed people with a mental illness, and found that their diagnosis changed once people were housed. They studied 75 subjects for three years. In these three years, only seven individuals who were studied became homeless. When Fichter first assessed them, 30% had mood disorders, 70% had alcohol dependence, 26% had anxiety disorders, and 80% had an axis I disorder. After a three-year period, Fichter reassessed the adults who had a mental illness and found a significant change in mental health symptoms. Mood disorders decreased to only 10%, alcohol dependence to 10%, anxiety disorders to 18%, and an axis I disorder to 64%; however, this study reported that just housing was not enough to decrease mental health symptoms. When Fichter placed these people in housing, they were also referred to necessary supports like a psychiatrist or a therapist (Fichter, 2006).

Homelessness has long-term effects on the individual. A qualitative study done by the National Institute of Mental Health (NIMH), studied 13 formerly homeless adults who are diagnosed with a mental illness in New York City. They asked the participants questions on their

experience of being homeless. It was a popular theme for participants to discuss how they had anxiety related to getting out and speaking up, as well as anxiety about leaving their apartment and about attending treatment groups in particular. They also discussed how leaving one's comfort zone raised concerns about being preyed upon or getting lost (Padgett, Hawkins, Abrams, & Davis, 2006). This study shows that even though these individuals are housed and in a safe place, the traumatic experiences they had while being homeless continue to affect them long-term. Again, housing alone does not take away their mental health symptoms and supports may be necessary to help them maintain their housing.

Housing the homeless who are diagnosed with a mental illness has been shown to improve enrollment in mental and physical health services. From the Padgett, et al. (2012) study, information was gathered from a woman who was homeless with a mental illness:

I'm diagnosed with chronic severe depression ... That's my psychiatric diagnosis. Then I have lupus ... I have chronic asthma, high blood pressure, menopause, oh my God, I can name so many things ... Before I was taking 30 something different medications every day. Now I'm down to 9 ... I have Graves disease also. (p. 425)

It is unclear how the participant developed these dual diagnosis, and if being homeless played a role in it. Burt and Anderson (2005) found that homeless people with serious mental illness who have stable housing are more likely to stay enrolled and engaged in mental health and physical health services. While homeless, it may be extremely difficult to schedule appointments, find transportation, and follow through with physician recommendations (e.g., taking medications, going to follow up appointments). A homeless person lacks the financial means to pay for transportation, medications, or insurance in order to receive appropriate treatment for their conditions.

Substance Use

Substance abuse is common among those who are diagnosed with a mental illness and are homeless. According to the Substance Abuse and Mental Health Service Administration (2011), research that was conducted in the past five years has shown that about 30% of people who are chronically homeless have mental health conditions and about 50% of the 30% have co-occurring substance use problems. That means that every other homeless person who has a mental illness also has a substance abuse problem. Padgett, et al., (2006), studied 13 formerly homeless adults who are also diagnosed with a mental illness in New York City and asked them questions on their experience of being homeless. One woman discussed how her mental illness and substance use had controlled her life:

I have so much to really dominate me. . . . I let drugs and alcohol control my life. I was so weak for so long. . . . I won't ever get back. . . you know I only went to high school. I almost joined the army and then I didn't 'cause I'd always get depressed and I would have been, I would have . . . maybe more than one trade. I would have seen the world. I think about that quite a bit too. Fifty-four years old, living in a home for women over 50. I think, I shouldn't be here (p. 465).

Substance use provides a way for those who are diagnosed with a mental illness and homeless to feel relief from their symptoms. McBride (2012) found that the 11 participants who were homeless and had a mental illness identified substance use as their main coping technique. Two participants explained their reasoning for using substances. "It makes me cry some nights. That is why I go back to the liquor or to the bottle... just to get through the pain, and the next day I wake up, alright, start again" (p. 56). Another participant stated "It's about the only way

you can get a good night's sleep, drinking some beer or something. That way you can lay down and you don't care if bugs are gnawing on you" (p. 56).

The use of substances can drastically change someone's life to the point that substances are all they are living for, thinking when and how they are going to get their next "high". As the previous participants have discussed, they are using drugs and alcohol to be able to sleep through the night from being homeless and also to cope with their mental health symptoms.

Providing housing and support can drastically decrease substance use. The study by Padgett and Henwood (2012), had two different phases. In phase one, they collected life histories of 39 men and women designed to show the positive and negative outcomes in their lives related to residence, mental status, and sobriety. The second phase was a longitudinal design with 83 homeless adults that were newly enrolled in their residential program. They were interviewed three times over three months. They found that "having a mental illness and history of substance abuse made shelters even more dangerous" (p. 192). One male participant was driven to attempt suicide rather than return:

The shelter was making me do all kind of crazy things. Drugs and alcohol, because it was all in the building. I wanted to get out of there so bad. They kept sending me back there. I didn't want to go so I took an overdose of medication. I went to Bellevue (p. 191).

A study by Padgett, Stanhope, Henwood, and Stefancic (2010), explored whether people with a mental illness and chemical dependency issues would do better in treatment first programs or housing first programs. They studied 27 participants in a housing first program and 48 in a treatment first program and found that housing first participants were significantly more likely to use services for substance abuse and less likely to permanently leave their program. In the treatment first program, 31 of them reported using drugs and alcohol during the study, 26 of

them went AWOL from their program and 14 experienced a full relapse into their addiction.

There were eight participants in the housing first program that reported relapsing; however, all of them remained housed in the program (Padgett, et al., 2010). This study shows that even though some people relapse, they are still able to remain housed in the housing programs. According to this study, going into treatment doesn't solve the problem and that supportive housing is a more permanent solution.

Incarceration/Safety

“An estimated one million persons with mental disorders are involved with the U.S. justice system alone” (Skeem, Manchak, & Peterson, 2011, p. 1). Homeless people who have a mental illness can be at high risk for being arrested. Koons-Witt, McShane, Schram, & William (2006) studied parolees and their life after parole and found that crimes committed by females and males is increasing and “not having safe and secure housing can prevent them from having their basic needs met” (p. 467). It is essential for people with mental illness who are released from prison to have housing as well as other supportive services, such as physical and mental health care and substance abuse services. More supportive services are needed to support these individuals and give them a second chance at life, and to prevent them from committing crimes again (Koons-Witt et al., 2006). A study done by Fischer and Shinn (2008), examined street homelessness and sheltered homelessness, the severity of psychological symptoms, and if these symptoms predicted violent or non-violent crimes. They studied 207 individuals who were homeless and had a mental illness. They found that “the likelihood of an individual committing a crime increased as homelessness and severity of mental illness symptoms increased” (Fischer & Shinn, 2008, p. 264). The homeless individuals were more likely to commit non-violent crimes, like breaking into a building to find shelter, suggesting that homeless individuals are not

necessarily violent, but are trying to survive. Findings suggested that greater symptom severity was associated with an increase in committing a violent crime (Fischer et al., 2008). Both the Koons-Witt et al. (2006) and Fischer and Shinn (2008) studies found similar results. By providing housing with supports to those who are diagnosed with a mental illness who were homeless, they are less likely to commit crimes due to having a place to live and assistance with their mental health symptoms.

Housing those who are diagnosed with a mental illness and homeless may decrease the number of subsequent convictions. Somer, Rezansoff, Moniruzzaman, Palepu, and Patterson (2013) conducted a study of 297 participants in October of 2009 to June of 2011. They found that the Housing First model is the most effective approach for ex-offenders. These participants all had a mental illness, were homeless, and had at least one previous contact with the justice system. On average they had more than eight offenses in 10 years. This particular housing program also provided them with optional services and then studied if the amount of convictions would decrease. They found that Housing First programs promote reductions in offending and reconviction among people who were previously homeless with a mental illness, with conviction rates decreasing by 70% once they were housed (Somer, et al., 2013). Putting someone with a mental illness in jail may not be the best way to rehabilitate them and also costs tax payers more money; however, this study contradicts what was previously mentioned by Smith where local supportive housing programs did not produce positive outcomes when it came to physical and mental health of those with criminal histories (Smith, 2011). They were not able to identify why those with criminal histories did not experience similar improvements as those without a criminal past. According to the majority of the research, the crimes that most of these individuals

are committing are due to homelessness, and if they are given a place to stay, the crime rate of petty crimes, at the least, will likely decline.

Stigma

Incarceration or institutionalization of those diagnosed with a mental illness and homeless has a negative impact on relationships. A study previously noted by Padget, et al., found that when someone was institutionalized for a while they lost relationships with their family and friends because they had their own problems and could not afford the “emotional time or effort needed to maintain the relationship” (Padget, et al., 2006, p. 425). Additionally, they found that the majority of the participants with a mental illness who were homeless had “tense relationships with family and friends”, due to mental illness, inadequate parenting, stealing to support a drug habit, and stigma related rejection (p. 424). One of the male participants stated:

When I was 16 years old, I was incarcerated ... I had a sex offense ... I did 12 years out of the 18 years, 'cause I was goin' through so much turmoil. I was fightin' in prison all the time. I was just wild back then. And using drugs. You know drugs you can get in prison, right (p. 425)?

Many times when people leave prison or a long hospital stay, they have nowhere to go. Many of them have not been able to stay in touch with family and friends as this study has shown. Also, many of them do not have a job to afford an apartment and it is extremely difficult to find landlords who will rent to those convicted with a felony. This often results in homelessness and possibly repeated offenses. This previous participant stated how he was “goin' through so much turmoil” back then; if he had had supports and stable housing, this may have been prevented. As research has shown, people who have

committed crimes and spent time in jail may need to have housing that follows the Housing First model.

Homeless people who have a mental illness have not always been perceived in the best way in society. Being a homeless person with a mental illness can put both society and the homeless themselves, in extremely vulnerable situations. This section will look at studies that have been done on the perceptions of what it's like to be homeless and have a mental illness.

Homeless shelters fail to meet the necessity of stable, long-term housing. As previously noted, Padgett and Henwood (2012), studied the opinions of homeless individuals regarding shelters. One participant stated “Wards Island you wake up at 6 o'clock and the whole dorm area is closed off 'til about dinnertime. They don't care where you go. Just go somewhere and then come back and eat” (p. 191). This is the reality of many shelters. They typically are not very accommodating and make people leave during the day; however, in the same study, they also interviewed a case manager who had a different perspective. He stated, “we hold groups, we do role-play for [housing] interviewing...this is what you can expect, this is what they're looking for. I teach them things like body language, eye contact, how to be honest without being too honest” (Padgett & Henwood, 2012, p. 191). He describes how they do try to assist the homeless in getting other housing. Additionally, Padgett (2006) studied how homeless women with a mental illness viewed trauma and substance use. The findings showed the need for safe, affordable, independent housing for homeless people with co-occurring disorders so they can restore their lost “autonomy” and help them recover by normalizing their situation. McBride (2012) found that people were actually getting their needs met when it came to food. One participant stated: “you pretty much get fed. Very few skinny people walking around. I never

worry about going hungry” (p. 54); however, participants identified numerous other needs that were unmet. Their biggest need was that they couldn’t find a safe place to stay.

The homeless who are diagnosed with a mental illness often suffer from stigma due to their mental health and report feeling like social outcasts. One individual in McBride (2012) stated:

Are you familiar with the word pariah? It is a social outcast, one to be despised and avoided. I have a situation just walking down the street, where people will cross the street in order to not walk past me and I look around and once they pass me they will go back to the side of the street (p. 57).

The participants went on to say how they feel like they’re not being treated like human beings. Padgett, et al., (2012), also agrees that there is a stigma that is significantly impacting homeless who are diagnosed with a mental illness. According to one of the participants, “I have brothers and sisters, but I decided to be more independent....you know there’s a stigma....they still look at me from a different perspective; they’re not educated about my illness nor do they want to be” (p. 425). People often can’t even begin to understand the struggles and situations of people who have a mental illness go through when they are homeless. People who are diagnosed with a mental illness have, time and time again, shown how resilient they are.

Homelessness for those who are diagnosed with a mental illness has shown to be a big problem, not only for the individual, but the society as a whole. Ending homelessness is not an easy task and would take society as a whole to end it. As this literature review has shown, there is hope for this population and there are many benefits to housing individuals who are diagnosed

with a mental illness with supports. These included reduced hospitalizations, increased medication use, decreased physical and mental health symptoms, and reduced costs.

Conceptual Framework

There are a couple different theoretical models that have guided this research: Housing First model, stress-vulnerability model, and systems theory. The Housing First model guided this research because it has shown that housing someone with supports has decreased the amount of time someone is homeless, and also helped prevent further episodes of homelessness. The Housing First model is a newer model and is set up to move the individual directly from the street to their own independent apartment, instead of having them transition from shelters, to transitional facilities, and then to their own apartment. The Housing First model is an approach that focuses on providing homeless people with housing and services as needed (National Alliance to End Homelessness, 2006). Research has shown that if people are given the option to receive services and aren't forced, they are more likely to maintain their housing. "A Housing First approach rests on the belief that helping people access and sustain permanent, affordable housing should be the central goal of our work with people experiencing homelessness" (National Alliance to End Homelessness, 2006, p. 1). Housing is not contingent on compliance with services; however, participants in the housing program have to comply with a standard lease. How programs focus on having supports may be beneficial to helping individuals keep their housing. The model shows that people typically do better when they are in their own home with services provided. Communities can significantly reduce the time that people are homeless and prevent further episodes of homelessness when people are given options on where they want to live and what services they want to receive.

Another model that helped guide this research is the stress-vulnerability model. In 1977, Zubin and Spring published their paper outlining the ‘stress and vulnerability’ model of mental disorders. The idea is that people become ill when the stress they face becomes more than they can cope with. Also, people’s ability to deal with stress varies. Stress that may be manageable to one person may be enough to cause another to become depressed or psychotic (Zubin & Spring, 1977). The stress-vulnerability model helped guide the research as it shows how stress and/or the environment can cause someone to have an increase in mental health symptoms or cause them to use substances. Also, someone who already has a mental illness is more vulnerable to stressors. It shows how the environment that someone lives in has a huge impact on their mental health symptoms. Because people with a mental illness are already vulnerable, they should be taking steps to reduce that vulnerability (e.g., taking medications, developing coping skills, social support, meaningful activities, and staying away from alcohol and drugs) (Hazeldon, 2014).

Systems theory also helped guide this research. Von Bertalanffy (1968), wrote that “a system is a complex of interacting elements that are open to, and interact with, their environments. In addition, they can acquire qualitatively new properties through emergence, thus they are in a continual evolution”. Systems thinking is set up to find and tell stories, look for trends, look for key causes using focus questions, identify beliefs and values, look deep into the structure, and plan interventions (Clark, 2012). This theory helped guide my research as I have investigated what has been happening with homelessness, why has this happened, and how we can improve the system. This study takes a further look into the risks and stressors of homelessness and at ways to improve the system for people who are diagnosed with a mental

illness and are homeless. This study also focused on the person as a whole, much like systems theory.

Methods

Research Design

This study used a qualitative approach, incorporating a semi standardized survey. This study obtained data for the purposes of understanding the social service professional's perspective of how housing the homeless with a mental illness is beneficial. This study used eight participants who voluntarily completed a 10-15 minute one-on-one interview. The researcher provided the participant with a copy of the interview questions before the interview and prompted them to review the questions again right before the interview. In the interview the researcher asked eight open-ended questions that related to mental illness, homelessness, and services. The participant was asked to answer the questions in their opinion taking into account their experience in working with this population. These individuals were audiotaped using a cell phone. By performing one-on-one interviews in a private location, the study was able to capture the true opinions of social service professionals on how housing the homeless who have a mental illness is beneficial. Data that was collected will help get a better understanding of what social service professionals think would be most helpful in working with the people who are diagnosed with a mental illness and homeless and how homelessness has an impact on the individual and society.

Sample

Participants were recruited through convenience sampling from several social service agencies in the Twin Cities metro area. The sample consisted of eight social service professionals. The researcher recruited both people she has previously worked with and referrals from committee members. Each individual was in the metro area. A memo inviting providers to

participate was sent to them. The participants needed to meet certain criteria to participate in this research. They needed to have currently or recently provided services to clients who have a serious and persistent mental illness who were either currently homeless or homeless in the past. Additionally, participants needed to have direct experience in working with a population of homeless who are diagnosed with a mental illness, but not necessarily expertise in the field.

Protection of Human Subjects

All of the participants in this study agreed to participate. Each participant and the researcher signed a consent form before starting the interview. The consent form followed the template provided by the University of St. Thomas. The researcher wrote the consent form and then the chair and the St. Thomas Institutional Review Board (UST IRB) approved the consent form before it was given to the participant. The consent form included the purpose of the study, the risks and benefits of the study, and issues of confidentiality. (See Appendix B for consent form). Strict confidentiality was maintained, as per the guidelines of the UST IRB and the NASW Code of Ethics. The records of this study are kept confidential. If a report is published, the researcher will not include information that will make it possible to identify the participants in anyway. As it was stated in the consent form, each participant was aware that their participation was voluntary and a refusal to participate would not result in any consequences.

Data Collection

The researcher used a semi-standardized interview as the primary tool for data collection and asked open-ended questions. Questions were formed after a review of literature on how housing has been beneficial for the homeless who are diagnosed with a mental illness. The researcher started out by asking the participant to explain the services that they provide for people in their current job, and what they feel someone who is homeless with a mental illness

needs to do to obtain and maintain their housing. More specifically, questions touched on the impact of being housed if a crime was committed or drugs were used, physical and mental health, cost effectiveness, accomplishing their goals, and the safety of those diagnosed with a mental illness and society (See Appendix C for complete list of interview questions). Narrative information from interviews were transcribed and subjected to a content analysis to explore themes from the sample (Berg, 2012).

Data Analysis Plan

The strategy that the researcher used is content analysis. The researcher first identified the research question, determined the categories, and read through the data (Berg, 2012). The researcher then transcribed the interview by creating three different Microsoft Word documents. One document contained the themes and subthemes that were highlighted. Each theme that the researcher found was highlighted in a different color and everything the researcher found similar to that theme was highlighted in the same color throughout the paper. The researcher then took the themes that she found and narrowed them down in relation to the research question by looking at the Word document and seeing which color was the most present throughout the data and deciding if it was a main theme or sub theme. Another Word document that the researcher used is one where similar words or phrases said by participants were highlighted in yellow. The third document contained the transcriptions, so the researcher was able to review them over and over again. The researcher began by sorting the information to what related to the literature review. The researcher read over the transcriptions five times to identify the main themes and interpret the categories further (Berg, 2012).

Findings

Demographics

Participants included eight social service professionals who were currently working with people diagnosed with a mental illness who were or are currently homeless. Three of them were supportive housing counselors, one was a therapist, one worked at an IRTS facility, one worked in a hospital setting, one worked on an assertive community treatment team, and one worked at a board and care lodge. Five of them had their degree in social work, with four of them having their master's degree. One holds a degree as a licensed alcohol and drug counselor, one has their degree and is licensed as a marriage and family therapist, and one did not have a degree, but had 20 plus years of experience. All eight of the participants were females ranging from age 28-60. Each of these participants had at least three years of experience working with people who are diagnosed with a mental illness and have experienced homelessness.

Basic Needs

After reviewing the data, there was one main theme (basic needs), four dominant themes (symptom management, supports, having your own place, and goals), and 15 subthemes that emerged. Meeting the basic needs of those who are diagnosed with a mental illness and homeless was discussed throughout the four dominant themes. The four dominant themes and 15 subthemes fit under basic needs. Basic needs discussions included having to find food to eat, having the main goal of finding shelter, and having a higher increase in emergency room visits when they were trying to get their needs met. The participants noted that when those who are diagnosed with a mental illness and homeless were housed, their goals, use of services, and crimes all changed due to no longer needing to find ways to get their basic needs met. Further discussion on basic needs will be discussed in each of the dominant themes and subthemes.

Symptom Management. A dominant theme that appeared was symptoms. Symptoms were discussed regarding people's physical and mental health and how having and not having housing impacted those symptoms. Also, drug use and use of medications were discussed in regards to what changed when people did not have housing versus when they did.

Mental Health Symptoms. The participants identified that managing mental health symptoms were very difficult when homeless. The diagnoses that were discussed by the participants were depression, post-traumatic stress disorder, schizoaffective disorder, anxiety, schizophrenia, bi-polar and personality disorders. All eight of the participants identified that having long-term housing helped decrease mental health symptoms. Five talked about seeing a decrease in symptoms immediately. One participant stated, "They usually feel pretty good. I would say that housing helps them come out of depression and they don't have as much anxiety and they just feel a lot better once they have a roof over their head." Alternately, three of the participants, all housing counselors, stated that housing actually increased their clients' mental health symptoms at first, and then with support and stability, their mental health symptoms started to decrease. One participant's experience is below:

People who experience depression, a lot of times we can see an increase in depression just because they go from homelessness, a very social setting, to a very isolated setting. They can actually feel more depressed because they become more isolative and they lost their support system that they maintained for so long. But I think with time those become more stable. I think with a diagnosis like bi-polar disorder, people who experience mania or manic phases they are going to be more stable. They generally find stability a lot faster.

Numerous participants stated that the mental health diagnosis played a role in how symptoms decrease. Some of the symptoms improvements that were mentioned included mood increases, decreased paranoia, a decrease in depression and anxiety, and a decrease in suicidal thoughts. One participant described the struggles her client, diagnosed with depression and anxiety, went through and how he was able to overcome being homeless:

I had a client once who was living in an abandoned building. He was having to walk to the shelter every day to shower and get food. This client also had severe anxiety, so he didn't want to stay in the shelters with all of those people. When he came into our program he had later told us that he was planning a suicide attempt. His plan was to jump off a bridge. Since he has been housed, he told us he no longer has been having suicidal thoughts because he has structure in his life, doesn't have to walk miles just to get a meal, and can focus on more important things in his life like his job.

Many of the participants also talked about anxiety in particular. They reported that once clients were housed, they didn't have to worry about anyone stealing their items, who was in the bed next to them, or where they were going to sleep. Participants reported that not having to worry about those things decreased their client's anxiety; however, one participant described how when her clients were first moved in, their anxiety increased, resulting in crises. "Right away, what I have come to learn is that everyone has a crisis once they move into an apartment. Some people, it's a lack of sleep leading to the move and they end up with more positive symptoms."

Medications. Another subtheme that was found is medications, tying closely with mental health symptoms. Participants discussed how important medications are if you have a mental health diagnosis. They also discussed how difficult it is for clients to obtain and keep medications when they are homeless. Data found from participants showed that having housing

alone would not necessarily improve their mental health, but other factors, such as medications, would have to be included. However, many of the participants stated that with housing they were more likely to keep their medications and scheduled appointments. One participant, who works in a hospital, discussed what often happens when people are discharged back in to a local homeless shelter:

When people have to get discharged back to Dorothy Day or back to the streets, they don't necessarily follow the discharge orders or take their meds as prescribed. They just have a lot more stressors. One, because they don't have a safe spot to put their meds or the paperwork, they just kinda have to throw it in a bag or in an envelope. It gets lost with moving.

Some of the participants talked about how when people are housed, they are more likely to take their medications because they have a place to put them, and when they take their medications it usually decreases their mental health symptoms. One participant stated, "We also see a change in their symptoms due to the fact that they're taking their medications." Another participant described how having housing affects their ability to take medications. "Getting them housing, I think people are a lot more likely to stay on their meds and meet with mental health providers which makes their mental health symptoms better." Medications not only improve mental health but physical health symptoms as well.

Unfortunately, according to the participants, some clients may refuse to take medications even if they do have housing. One participant noted that it's important to meet each individual where they are to determine their reasoning for not taking medications. One of the participants described what some of her clients think about their medications and what she does to help with the situation:

I am a really big fan in always asking if they are taking their meds, and if they aren't, why, and I find motivational interviewing very useful around that. A lot of people start to feel like now I have somewhere to live, I am doing really well; I don't need my meds (sigh). We try to avoid that mentality, but it happens far more than you'd like.

Physical Health Symptoms. Six out of the eight participants discussed how people's physical health improved once they were housed for a variety of different reasons. They discussed how once their clients were housed, they were able to keep their medications and insurance cards in one place, had a more balanced diet, providers were more likely to be able to reach them to help navigate the health system and schedule doctor appointments, and it was easier to set up transportation. Some of the participants also noted that their clients no longer had to focus on housing and could focus on other things, like their physical health. One participant, who works at a hospital, was able to share her experience with changes in their physical health once they were housed:

We had someone with diabetes who was at Dorothy Day and she wasn't taking her insulin or checking her blood sugars because she couldn't get on a set schedule. She actually came back to the hospital a couple weeks later for something else and she said she got a subsidized apartment and was able to keep her medications and insulin in one spot and have a better schedule.

Another participant who works at a board and care lodge discussed how easy it was for her clients to improve their physical health because of the services they had onsite:

Their physical health, I think, improves a lot, at least in our setting. They get medical care right where we are located. We have three nurse practitioners and doctors right onsite which helps them to go in if they have a cold or something like that. Also, we have a

fitness room which helps improve their physical health cause they're able to exercise more and build up the strength and stamina that they need.

Two of the participants reported that they really hadn't noticed a difference in their client's physical health symptoms. One of the participants reported, "I haven't really noticed a difference, but I haven't known them for very long before they become housed generally. I would assume that it improves except with some of my older folks who are getting older." Another participant stated, "I don't really think that their physical health does change. I mean people in shelters can still get medical care."

Substance Use. A few participants talked about how substance use affects people's mental health symptoms and also can affect their ability to care for themselves. Additionally, people often cope with their mental health, and sometimes physical health, symptoms by using substances. Many of the participants discussed how their clients often have dual diagnoses. Some of them were able to identify what seems to help those with substance issues. One participant stated, "So practicing harm reduction. They can use it in their home environment, not out in the streets walking around with a bottle or doing drugs and getting arrested and getting into trouble." Another stated that "Things to do during the day. That's really a big one that idle time really gets to people. The clients I have that use chemicals, if there's a lot of idle time they'll fill it with drugs." Another participant stated, "Decreasing their mental health symptoms can help decrease their substance use and vice versa." Participants discussed how clients using drugs in their housing can create crises, and clients will often use their money towards their addiction and not their rent. One of the participants shared what had happened to one of their clients housing while using substances:

A lot of the clients that I work with, they are using substances to cope with their mental illness. I have seen a situation where housing has been provided and the client was not able to hold on to the housing due to chemical dependency issues and bridges have been burned and they are not able to utilize those resources that were available to them.

Many of the participants expressed how important it was to help clients with both their addictions and mental and physical health symptoms, as they closely relate to each other. Also, that having housing alone does not necessarily decrease substance use or mental health symptoms, but that supports and resources may also be necessary.

Supports. Many of the participants discussed how having housing helps to decrease their client's symptoms, but that having supports was key in maintaining housing. Participants discussed how having resources and the use of services often changes when someone is homeless to when they become housed.

Collaboration. Collaboration had come up a few times with participants. Collaborating appeared to be important when it came to helping individuals maintain their housing. Collaborating with different landlords, family members, case managers, psychiatrists, or other providers was helpful in being able to be on the same page and to be able to help the client in a holistic way. One of the participants, a housing counselor, shared a situation where she collaborated with a landlord to advocate for her client:

In my position I do a lot of collaborating with landlords. There's been times where some of my folks have been really close to eviction and then I've been able to talk to the landlord and tell them what's going on and tell them what things I can do to help the client get better.

Another participant stated, “At the hospital we often collaborate with the client’s case manager or family members to make sure when they leave the hospital that they got the services and support set up to prevent them from needing to come back.” Some of the participants discussed how at times the clients get confused with what their provider was saying or they forgot what the recommendations were. Through collaboration, those providing supports can reiterate the provider’s message to the client and assist them with following through with the recommendations.

Maintaining Housing. Participants were asked what is needed for people coming off of the streets who are diagnosed with a mental illness in order to maintain their housing. The most common response was provider help, support and resources. Additionally, participants also described a variety of things clients need assistance with. Five out of the eight participants stated that basic independent living skills need to be taught, such as budgeting, preparing meals, scheduling appointments, and communication skills. Many of their clients do not know how to budget and pay their rent each month. One participant noted, “They need help with budgeting, overseeing finances, ensuring that rent and bills are paid. I think those are huge.” Getting their basic needs met was more of a priority, but once they’re housed, focusing on budgeting was discussed as more of a priority. Additionally, three of the eight participants described how many of their clients don’t understand the rules of their lease and that they often have to remind them of the rules or explain their lease to them. “Some people may have difficulty in understanding or reading a lease agreement, so maybe that needs to be explained to them.” Participants discussed how explaining and going through the rules of the lease with them is helpful. One participant from the hospital stated, “A lot of these folks in the hospital just do what they want, when they want, and they don’t have as many rules to follow. When you get into an apartment, you have

neighbors and space and leases.” One participant described how clients often do not know how to advocate for themselves. “Sometimes it’s hard for clients to express themselves in a way that is favorable for landlords.” Coaching the client on what to tell a landlord and what not to tell them is important in helping them obtain and maintain housing.

Transportation was also a huge barrier in maintaining housing. Participants discussed that when clients first become housed, they often don’t know how to get access to transportation, especially if they are not on the bus line. Participants discussed helping them get set up with Metro Mobility or Minnesota Non-Emergency Transportation (MNET) to get to appointments and other activities as needed. One participant described how having reliable transportation helps people maintain their housing, “I think they need access to medical care and mental health care when they are housed and transportation to get there in order for them to maintain their housing.”

Transportation was also discussed in regards to being able to get to the grocery store. One participant stated, “Carrying canned goods on the bus can be super inconvenient and challenging.” Three participants thought that helping clients get food from the grocery store and food shelves was necessary in helping them maintain their housing. Participants also noted that social activities and structure was also a main problem for their clients in maintaining housing. The participants talked about how there is guilt, clients may feel something’s missing, be isolative, or have an increase in depressive symptoms. One participant discussed what she felt would be helpful for people to maintain their housing, “I think the other thing that people with mental illness need in order to maintain their housing is places that they can be social. Community service centers, drop in centers, places where they feel welcome and wanted.” Another participant described what she says to her clients when they become isolative, “Sitting at

home being bored does not help with your mental health. What can we get you involved in, and generally I find that community support programs are the easiest thing right off the bat.”

Lastly, participants discussed their clients recognizing their mental health symptoms and taking their medications as a main issue in maintaining housing. Participants talked about how clients often need support around managing their mental health symptoms and remembering to take their medications. One participant stated:

And with meds and support, sometimes symptoms do fluctuate so having someone there to kind of help them notice their early warning signs. So it's not to the point where they're being intrusive with their neighbors pounding on the door, running through the halls, something that's really disruptive. That's a way I've seen people loose there housing. So having some help to manage that ahead of time would help them maintain their housing.

Resources and Providers Available. Supports were talked about as an important factor for those who have a mental illness and are trying to maintain their housing. There are many different supports and resources that are available to those who have a mental illness. Some of the supports that were mentioned included supportive housing counselors, psychiatrists, independent living services workers, case management, vocational specialists, assertive community treatment (ACT), and Adult Rehabilitation Mental Health Services (ARMHS). The services that participants recalled providing for their clients included making referrals, taking them to appointments, advocating for them, treatment groups, assistance with obtaining and maintaining housing, obtaining resources for furniture, assistance with independent living skills, management of symptoms, medication management, and assisting with building structure

in their lives. Even though participants talked about how important it was for clients to have supports and resources, one participant discussed how she tries to limit her client's resources: "I've also seen where they get really confused because they're going to different hospitals and getting so many different resources and they get overwhelmed and then they don't do anything. So I limit their resources quite a bit."

Navigating services was a main topic that participants mentioned when asked how they help their clients. Six out of the eight participants discussed how they help them navigate services and get connected with other providers. One participant talked about how if she couldn't help her clients, then she refers them to someone else: "I will look at an application with somebody, but I don't put a lot of effort into actively engaging and trying to find them a job. I just refer them to somebody like a case manager or vocational rehabilitation." Another participant shared how she helped her client navigate services as well: "I have a client who when he was homeless didn't have any providers in place and hasn't gotten a physical in years. Once we were able to house him, he got a primary care doctor, dentist and a therapist." Sometimes family is not available to assist the client with maintaining their housing and it is important for providers to recognize when support is needed.

Family. Family was talked about amongst four of the participants in regards to the clients who no longer have a relationship with their family members or their families are "burnt out" due to mental health or chemical dependency issues with the client. One participant stated, "I work with veterans who are basically living with family members and they cannot deal with their mental health and chemical dependencies anymore. So we house them here." The participants also discussed how when they're homeless their priority isn't their family and the relationships they have, it's often trying to find housing. One participant discussed how her client's natural

supports are often lacking: “The population that I work with, they don’t always have natural supports that are available; whether that be that they burned bridges with their natural supports or maybe the family is just tired of what’s all going on.” Participants discussed how an important part of their clients’ recovery is building back up those natural supports.

Use of Services. Participants were asked how the use of services, like hospital admission, changes when people are homeless versus when they are housed. All eight of the participants stated that when people are homeless, they are using the emergency room more often compared to when they are housed. There was a variety of reasons that were relayed, one of them being the weather. Three participants stated that in the winter months, there are more people who are homeless going to the emergency rooms. Two participants identified that the shelters are often over-crowded, so using the emergency room is a way to get their basic needs met. One participant stated, “More go to the emergency rooms saying that they are suicidal, especially when it’s cold out. They know the strategies of what to say so they can be admitted for that night so they can have a warm place.” Some other factors participants identified as a reason for using the emergency room more often when they were homeless included not having access to a phone or not having insurance or their insurance cards to schedule appointments. Transportation was also a barrier when it came to setting up doctor appointments. Participants discussed how a homeless person may not even know where they’re going to be the next day and it may be very difficult to arrange transportation for medical appointments. “They don’t have the resources available to get those appointments set up. Or they don’t know where they’ll be living or who is going to bring them to that appointment.” Three participants reported that once their clients are housed, they are a lot more likely to get preventative care. “They’re also doing more preventive types of medical stuff, so they’re getting that physical rather than just using medical services

when they're sick or in pain." The increase in preventative care may be contributed to the help from service providers. One participant discussed how once people are housed, they are more likely to have case management or ACT. "I think there's less use of case management and ACT services because it's harder to stay in touch with them. It's nice when someone's housed because they can use case management and decrease those more expensive emergency room visits."

Participants described how case management and other services can assist clients in filling out paperwork, scheduling appointments, and following up with recommendations. One participant agreed that housed clients use fewer services; however, she also reported that if they have a medical condition, they are more apt to get medical help once they are housed. "They certainly don't use the hospital as frequently, unless they have a medical condition that like maybe when they were homeless would be ignored, and now that they're housed, they feel inclined to see a doctor and remain healthy." One participant described how detox was also a service that they felt was being used more when people were homeless. "They may be using their money to get through the short term by using drugs or alcohol. It seems like they're more likely to get picked up by police, so spending time in detox or the emergency rooms." According to some of the participants, in order to decrease the emergency room visits, housing needs to be more available for their clients.

Affordable Housing. Five out of the eight participants stated how there is not enough affordable and safe housing for their clients. One participant stated, "I know there needs to be a lot more affordable housing for folks with mental illness and not tearing places down but making things better, but of course the bottom line is that this is all going to cost money." Some of the participants discussed how due to the lack of affordable housing, it was even more difficult for

their clients with a criminal history, bad credit, or unlawful detainment to find housing. One participant stated:

I would say one of the most frustrating parts of it is trying to find housing for folks with the different barriers that they have to go through. If they have had any unlawful detainers or, uh, just not having good references for housing, it brings up a lot of hardships for them to find any type of housing, even if it be poor housing.

Three of the participants described how they explain to their clients that landlords don't like criminal backgrounds, and if they have criminal backgrounds, they try to prepare their clients that they may have to rent from a "slumlord". "And that's a really big point I hit home with them, is that landlords don't like criminal backgrounds." One participant described how the Section 8 waiting list could be seven plus years long. "That's crazy if you ask me. Someone is supposed to be homeless for seven plus years. That would have to change someone and who they are as a person." Another participant stated, "I know that sometimes they tear down buildings that could be used for low income people. That is unfortunate."

Having Your Own Place. Having their own housing was talked about in length amongst the participants. It affects societies and the client's safety by decreasing their desperation and improving their mental health stability, thus reducing the number of crimes they commit. One participant stated "When you can lock your door at night, that's a good thing."

Defending Their Housing. As mentioned above, having your own place is much safer for both society and the client; however, two participants discussed how when clients are first housed, they need to learn how to defend their housing:

One of the things that I think people transitioning from homelessness into an apartment deal with is that they feel guilty because they are getting off the street and their friends aren't. They want to invite them in, and the next thing you know, the landlord is calling and saying, hey, there are parties going on there every night. So I think just to learn to be very protective and that it is okay to defend their home and keep it for them.

Participants discussed how if clients didn't learn how to defend their housing, they often saw their clients friends come in and use drugs and damage their apartments. One participant stated "I've worked with one who had quite a bit of damage in his apartment with people coming and going. That's actually a huge concern of landlords that I have seen with the high traffic that comes through."

Another participant described how having your own home for the first time can be very lonely and they may feel like something is missing in their lives. Often times, homelessness can be a very social thing and there are often people always around. I once had a client say "Ya know, having my own space is great, but the reality is that when I go into my apartment and shut the door it's just me and the T.V. there, and that can be really lonely". Two participants discussed how their clients are often very vulnerable when they come off of the streets. They haven't been able to build their skills and supports yet. One participant stated, "I think our clients can be very vulnerable, especially if they have the street mentality of well, I'll help you or give you a place to stay because my friends have helped me with a place to stay."

Safety. All eight of the participants described how society is safer when people who are diagnosed with a mental illness are housed, and seven participants described how the client is safer once they are housed. Some of the reasons mentioned for this increase in safety were that clients were more likely to be on their medications, have a decrease in mental health symptoms,

experience less desperation and vulnerability, have reduced criminal activity, and have an environment where their basic needs were met. Five out of the eight participants reported that clients were safer because their mental health symptoms decreased. One participant stated, “Someone who is paranoid and is on meds is going to feel less likely to have to defend themselves or get into some more of those aggressive behaviors that can happen.” Another participant stated, “I think this kind of goes back to the likelihood of being on meds and meeting with providers. A lot of our clients are at risk of harming themselves or harming someone else.”

Participants reported that their clients just being able to have their own place to go back to when they are symptomatic made them less likely to go to the hospital or end up in jail. One participant reported, “When you are homeless, you are in that survival mode. It’s scary and there is a lot of danger around. That can make you lash out a lot quicker because you are so fearful.” One participant described how she has heard of her clients having to fight over a shelter bed. “I know that shelters have had issues with overcrowding and people fighting over the beds and that has also caused client to client safety to be in jeopardy.”

Crimes Committed. All eight of the participants described how the crime rate decreased once people were housed. Seven of them discussed how the crimes that the majority of their clients were committing were crimes that pertained to getting their basic needs met. These included stealing food, trespassing, public intoxication, prostitution, and public urination. Once they were housed and their basic needs of food and shelter were taken care of, the crimes committed decreased significantly. One participant stated, “I had one client who used to be involved in prostitution. She wouldn’t do it now, but at the time she was homeless and she didn’t feel like she had any other choice.” Another participant stated, “When they’re homeless, they

don't feel like they have anything to lose, they may be more apt to steal food. Then when they have a home, things start falling into place.”

Though five of the participants talked about how their clients still commit crimes once they are housed, the type of crimes changed and the overall crime rate decreased. Some of the participants were not sure if having housing would stop people from committing certain crimes like selling drugs. One participant noted, “If someone really has a criminal mind and a criminal mindset and is bent on committing criminal acts, I don't think housing is going to deter that.” Three of the participants described how their clients sometimes still commit crimes because of their mental health or chemical dependencies. One participant shared an example of a client she works with on how his mental health symptoms affect his decision making skills. “I have one gentlemen who, when he starts to decompensate, becomes very impulsive and he recently broke a law or two. But when he is stable and taking his medications, this doesn't typically happen.”

Stigma. Stigma was talked about amongst two of the participants in regards to homelessness and mental illness. One participant discussed stigma in regards to people being stigmatized when finding housing. “It's unfortunate because sometimes with people who do have a mental illness and because they are being stigmatized, they may be more apt to be involved with slumlords or people who are not as kind.” The participant went on to say that due to stigmatization, people with a mental illness often need to live in places that may not be up to the standards of living that the general population enjoys. Another participant described stigma towards homeless individuals. “Homeless folks are very resourceful, but they all kinda stay in the same area, and I think other community members try to stay away from that area and they get a huge stigma, that's the homeless folk area.” Stigmatization can also affect those who have a mental illness from accomplishing their goals.

Goals. Participants were asked how their client's goals changed once they were housed. Participants discussed how goals often change when someone is homeless to when they become housed.

Focus No Longer on Housing. Participants described in detail how their homeless clients were focusing on getting their basic needs met and trying to find housing. After they no longer had to focus solely on survival on the streets and the search for housing, they could start to look at other areas like physical health and obtaining employment. One participant described how their clients typically think when they are homeless. "How am I going to live, how am I going to be safe, so if those things are provided for them, you're going to be able to look at other goals that they may have." Another participant stated, "For most folks, the only priority is housing; they don't really care about employment or family or their health." Participants described how their basic goal is to get their needs met, and once this is accomplished, they can start to have a more fulfilling life and focus on other goals.

More Opportunity. Participants discussed how once clients were housed, there was more opportunity for them. "I think it gives them good self-esteem, so it motivates them to keep moving forward. Homelessness is a heavy burden to carry. I just think it will motivate them to work towards their recovery with mental illness." Five participants still brought up the importance of learning independent living skills and education around their symptoms for them to continue maintaining their apartment.

Participants discussed how their clients were able to choose what they wanted to work on once they were housed instead of just focusing on getting their basic needs met. One participant stated, "Meeting that basic need, they can focus on more kinds of things that are more fulfilling to them like school and work." Another participant discussed how she helps clients once they

have housing: “Once they are housed, we are able to work with them on whatever their goals are, sometimes it’s finding a job, getting off of their commitment, bettering their relationships with family members, etc.” Another participant described how client’s goals are much more attainable once they are housed and that they often have supports in place to help them:

Well it makes them much more attainable because they have a home base to operate from, and again, because the housing typically comes with services, they have more resources available to help them achieve their goals too. I think it gives them more opportunity to reflect and think of more meaningful goals; they can relax and don’t have to be so vigilant. I have a client who once he was housed, he was able to get a part-time job as a cook. He loves that job and it makes him feel like he has a sense of purpose now.

Discussion

This study was conducted to further understand the social service professional’s perspective on how housing the homeless who are diagnosed with a mental illness affects the individual and society. The data collected from the research demonstrates the impact that housing has on their symptom management, goals, and use of services, as well as the importance of the supports that need to be in place in order to help them maintain their housing. The findings of this study support data found in the literature review. Housing with supports for those diagnosed with a mental illness reduces costs, improves mental and physical health, and reduces crime rates. By providing the basic need of shelter, individuals are able to focus on other areas such as their health, building relationships, and obtaining a job or schooling, while reducing the likelihood of committing a crime to obtain that basic need.

Both the literature review and the interviews conducted regarding physical and mental health symptoms and housing support, for the most part, support the stress-vulnerability model

that people become ill when the stress they face becomes more than they can cope with (Zubin & Spring, 1977). All eight participants interviewed agreed that housing helps to decrease mental health symptoms in the long run, although three participants noted that symptoms often got worse due to isolation before they got better. It was also noted that their initial mental health diagnosis determined how their symptoms would decrease. This is supported by the Fichter (2006) study that showed symptom reduction for different disorders after participants were housed for three years. Housing those who are diagnosed with a mental illness and are homeless with supports allows them to better manage their physical and mental health through increased use of preventative care and doctor visits, obtaining and keeping medications, and adherence to provider follow-up. Additionally, an improvement in overall health (e.g., decreased anxiety, depression, and paranoia, improved diet) is seen simply from being off the streets and in a stable environment. This improvement in mental and physical health results in a reduction in substance use and emergency services required for these individuals.

This study showed that support was as important as housing for those who are diagnosed with a mental illness in order to decrease homelessness. Providers play a major role in helping those who are diagnosed with a mental illness maintain their housing by teaching independent living skills, providing education around leasing, recognizing mental health symptoms, and scheduling reliable transportation. Those who are diagnosed with a mental illness and are homeless often lack supports from family and friends due to “burn out”. Upon being housed, they are more able to focus on their recovery and building those relationships back up. This is an important step in their recovery as it can reduce their mental health symptoms and increase the likelihood of them maintaining their housing. Finding affordable housing has been found to be extremely difficult for this population due to the competitive housing market, lack of income,

and past evictions or criminal history. There are a variety of supports that are available to those who are diagnosed with a mental illness, and if clients choose to participate in these services, studies show that they will be more likely to obtain and maintain their housing.

When individuals who are diagnosed with a mental illness are able to have their own place, they are given more opportunity to accomplish their goals, notice a decrease in their mental and physical health symptoms, and are better connected with providers, resources, and their family and friends. Both the experiences of the individuals who were interviewed and previously conducted research support the fact that housing someone with a mental illness is safer for both the individual and society. When individuals are housed, they are more likely to be on their medications and experience less desperation and vulnerability, thereby decreasing their mental health symptoms and substance use (Padgett and Henwood, 2012). This, in turn, significantly decreases the rates of hospitalization and incarceration [(Koons-Witt et al., 2006), (Fischer and Shinn, 2008), (Somer, et al., 2013)]. To make housing more successful, support around how to defend their housing and their leasing terms are necessary.

The interviews conducted highlighted how a shift in goals occurs as the homeless who are diagnosed with a mental illness obtain housing. While homeless, the main goal is to locate long-term housing, leaving little time and resources for anything beyond that. Once they are housed and their basic needs are met, they are more likely to search for employment, additional schooling, or volunteer opportunities, in addition to improving relationships with family and friends. Prior research regarding goals of those diagnosed with a mental illness pre- and post-housing was lacking and may serve as an area for further investigation.

Implications for Social Work Practice

Social workers play a large role in helping clients who are diagnosed with a mental illness obtain and maintain their housing. There are many barriers for those who are diagnosed

with a mental illness to overcome in attaining and maintaining their housing and it is imperative that social workers act as an advocate for them. This can be done through identification of barriers and problem solving to reduce those barriers with the client. Social workers should receive additional training on how to help those who are diagnosed with a mental illness to obtain and maintain their housing and also how to advocate with landlords.

It is also imperative that social workers meet each client where they are at in their recovery process and focus on the housing first approach. Social workers should understand how homelessness affects one's mental illness and what to be aware of once that client becomes housed. Social workers need to understand that while there are many benefits to housing, there also may be some negatives as well.

This research found that simply providing housing alone may not be enough to assist those who are diagnosed with a mental illness in having long-term housing. Support services are usually required to maintain their housing. Social workers can assist their clients with explanations of their leasing agreement and education around meal planning and budgeting.

The supports provided by social workers assist the clients in getting their basic needs met. In addition to helping their clients find and maintain their housing, social workers must also collaborate with other providers to make sure the client understands their mental health symptoms and is taking any required medications. When social workers are able to provide these supports, the frequency of emergency room and psychiatric hospital visits and incarceration rates decrease, thus reducing the costs to society.

Implications for Policy

Housing for the homeless who are diagnosed with a mental illness has been a major issue for decades. Since the rental housing market has been so competitive lately, housing has been becoming more and more limited. It is important for policy makers, and social workers to realize

the importance that access to affordable housing needs to be supported as a priority in legislation as well as financially. HUD reports that there is a shortage of affordable housing for those who have very low incomes. About 200,000 rental housing units are destroyed annually. As the cost of rent is continuing to increase, the income of people who are in poverty is continuing to decrease (National Coalition for the Homeless, 2009).

The majority of clients that social workers serve are dependent on government assistance to meet their basic needs. Advocacy at a legislative level for affordable housing, benefits, and resources that support basic needs is important in reducing health care costs and use of emergency rooms and hospital visits. There is a current plan in place call the Olmstead Plan put on by the Department of Human Services and Minnesota Housing Finance Agency. This plan allows “people with disabilities will choose where they live, with whom, and in what type of housing” (Olmstead Subcabinet, 2013, p. 10). Social workers and policy makers should become more educated and focused on this plan so that a community as a whole can work towards this goal of allowing individuals who are diagnosed with a mental illness to choose where they want to live.

Implications for Research

Numerous studies have been conducted on how homelessness affects those who are diagnosed with a mental illness. Additional research should be developed around what specifically works for those diagnosed with a mental illness to maintain their housing. Preferably, more qualitative research from clients in their experience of what helped them obtain and maintain their housing. Also, an additional study could include interviewing city officials, policy makers, clients, and social workers to determine how to acquire funding and the best locations for more affordable housing. Lastly, a detailed look into the goals of those diagnosed with a mental illness pre-and post-housing could serve as a validation in the argument for

subsidized housing of the homeless. Upon housing, the goals of finding employment and additional schooling were noted among those with a mental illness who were formerly homeless. If employment rates increase significantly after housing is provided, this would further justify the importance of housing this population in reducing costs to society.

Strengths and Limitations

Based on its design, this qualitative study has several strengths. The questions that are included in the interview are supported and informed by previous research on housing the homeless who are diagnosed with a mental illness. Thus, the findings are easily compared and contrasted with other studies. Also, the interview questions were distributed to the research participants prior to the scheduled interview, giving them time to formulate well thought out responses. Not only did it increase the likelihood of the participants' response from a professional standpoint, but it also afforded for in-depth responses to the interview questions containing information that may not have been otherwise obtained. This study and the validity of its findings are further strengthened by the use of digital recording and transcription. Also, because the individuals who were interviewed had direct contact with the population, the information provided was very detailed and was easily comparable to other participants.

Despite the strengths noted above, there are also limitations to the study. The collection of data only included social service professionals' perspectives of how housing the homeless who are diagnosed with a mental illness is beneficial. This study leaves out the perspective of those who are diagnosed with a mental illness and are homeless, which may provide crucial information into the causes of homelessness and what can be done to solve the issues faced by these individuals. This study also focuses more on the benefits of housing someone who is homeless with a mental illness and not the negatives. Also, the fact that people were audio taped

may have taken away from some of the honesty in answering the questions in fear of being judged or having the information used against them in some way.

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Appendix A

Date:

Dear Social Service Professional,

My name is Kayla Sprenger, and I am a graduate student at the University of St. Thomas (UST) and St. Catherine University (SCU) School of Social Work. I am conducting research for my Master's clinical research paper. I have selected you as you are a social service professional who provides services to clients who are homeless and diagnosed with a mental illness.

I am conducting a study from social service professionals to identify their perspectives of if it is beneficial to house those who are homeless and diagnosed with a mental illness. This study will analyze the social service professionals perspective of the impact that housing someone has in multiple areas of their life such as, mental and physical health, drug use, crimes committed, and cost. Further more, this study will be gathering information from social service professionals on specifically what people with a mental illness need to obtain and maintain their housing.

To be eligible for this study you must 1. provide or recently provided services to clients who have a serious and persistent mental illness. 2. work with individuals who are either currently homeless or were homeless in the past. 3. Agree to participate in the study. You do not have to have expertise in this field but will have to have some direct experience in working with this population.

I will conduct an interview that will last approximately 25 to 35 minutes and you will be asked 8 questions. Confidentiality as it relates to your agency and you will be safe guarded. Refusal to participate will not have a negative impact on your relationship with UST or SCU. Please feel free to contact me with any questions.

Thanks you,

Kayla Sprenger

Appendix B

CONSENT FORM

UNIVERSITY OF ST. THOMAS

Housing with Supports for the Homeless Who are Diagnosed with a Mental Illness: The Social Service
Professionals Perspective

[658038-1]

I am conducting a study about if *housing people with supports who are homeless and are diagnosed with a mental illness is beneficial to the individual and society*, the perspective of social service professionals. I invite you to participate in this research. You were selected as a possible participant because you are a social service professional and have experience working with homeless people who are diagnosed with a mental illness. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: *Kayla Sprenger, as part of a graduate course in research and is being supervised by Karen Carlson, advisor at the University of St. Thomas.*

Background Information:

The purpose of this study is to gain a better understanding of social service professionals views on how housing people who are homeless and diagnosed with a mental illness is beneficial to the individual and society. My hypothesis is that housing with supports for those diagnosed with a mental illness improves health, reduces cost and crime rates. I will be doing a qualitative research study and will be using a semi standardized interview as the primary tool for data collection. My questions are as follows: What population do you work with and what are the services that you can provide for people in your current job? When someone becomes housed, what changes do you notice in their mental health symptoms? Give specific examples on why you think this is. How do you feel people's physical health changes once they are housed? Give specific examples on why you think this is. What changes have you seen in your clients in regards to committing crimes once they are housed? What changes do you see in the way clients use services/hospitals when they are homeless compared to when they are housed? After a person with a mental illness becomes housed, how do you think that affects their goals? In your experience what changes have you seen in regards to clients and societies safety once they are housed? What do you think people that are housed with a mental illness need help with to maintain their housing?

Procedures:

If you agree to be in this study, I will ask you to do the following things: Participate in a 25 to 35 minute one on one interview for one time. You will be asked 8 questions and if you don't feel comfortable or do

not know the answer to the question, you do not have to answer it. The interview will also be audiotaped.

Risks and Benefits of Being in the Study:

The study has minimal risks. First, some of the information from the audio tape will be presented in 2 separate presentations in front of an unidentified amount of people. One presentation will be in front of various people at the University of St Thomas and the second will be in front of staff at Carlson Drake House. Second, some of the information from the audio tape will be placed in my clinical thesis paper which then will be placed online for the public to see. I will take the following steps to prevent any risks: The audio tape will be destroyed 1 week after the recording is done. I will destroy it by deleting the recording. I will also delete any potentially particularly identifying information and it will not be entered into my paper. The consent forms will be kept in a separate folder that will be kept in my locked safe at my own home. The transcripts and consent forms will have a corresponding number on them and will be kept separate at all times. The transcripts will be kept on my personal computer that also will be password protected. There are no direct benefits (such as payment) that you will receive for participating in this study.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way. The types of records I will create include recordings and computer records. The computer records will be on my password-protected personal computer that no one else has access to and the records will have no identifying information on them. The transcripts will be destroyed the day after my presentations. The audio tapes will be kept on my password protected phone and will be destroyed a week after they are recorded. Each participant will sign a consent form. The consent forms will be kept in a separate folder and put in my locked safe at home. The transcriptions on my computer will always be kept separate from the consent forms and will have a corresponding number on them to identify the participants. Some of the information will be presented in front of an unidentifiable amount of people that are allowed to attend my presentation at the University of St Thomas and also in front of Carlson Drake House staff. Also, some of the information will be included in my clinical thesis paper and will then be submitted online to the public by staff at the University of St. Thomas.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with St. Catherine's University, University of St. Thomas, or the School of Social Work. Should you decide to withdraw, data collected about you will not be used. If you decide to participate, you are free to withdraw at any time up to within one week of the interview. Should you decide to withdraw data collected about you will not be used. You are also free to skip any questions I may ask.

Contacts and Questions

My name is *Kayla Sprenger*. You may ask any questions you have now. If you have questions later, you may contact me at 612-616-3962. You may also contact my advisor, Karen Carlson at 651-962-5867. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6038 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I consent to being audiotaped.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix C

Questions

What population do you work with and what are the services that you can provide for people in your current job?

When someone becomes housed, what changes do you notice in their mental health symptoms?

Give specific examples on why you think this is. How do you feel people's physical health changes once they are housed?

Give specific examples on why you think this is. What changes have you seen in your clients in regards to committing crimes once they are housed?

What changes do you see in the way clients use services/hospitals when they are homeless compared to when they are housed?

After a person with a mental illness becomes housed, how do you think that affects their goals?

In your experience what changes have you seen in regards to clients and societies safety once they are housed?

What do you think people that are housed with a mental illness need help with to maintain their housing?

