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Critique of the Group Home Model in Addressing Homelessness for People with a Mental Illness

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Critique of the Group Home Model in Addressing Homelessness for People with a Mental Illness

by

Brenda K. Blaisdell, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the

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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

The purpose of this study was to explore the strengths and limitations of the group home model in addressing homelessness for people diagnosed with a mental illness. This study attempted to collect qualitative data from group home owners who serve people who have a mental illness and have been or are at risk of homelessness. Researcher was unable to recruit a sample for this study due to barriers in recruiting a sample. The barriers to recruiting a sample include: *low sample; inaccessibility of group home owners; lack of investment by group home owners in the research process and a lack of buy in to program evaluation of group homes by the owners*. Research recommendations to address these barriers in the future are also discussed. Given the complex problem of housing shortage for people with a mental illness, it is important that we continue to research this issue with the hope of reducing homelessness.

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Introduction

According to a Wilder Research study, the approximate number of homeless people in Minnesota on any given night is 13,100 (Wilder, 2009). However, when redefining homelessness to include those who have experienced homelessness for shorter periods of time and accounting for that estimate throughout an entire year, Wilder found that 46, 400 Minnesotans experience homelessness at least once during the course of a year. Furthermore, in comparing this study to a similar 2006 study conducted by Wilder, research indicates that the number of homeless adults who accessed emergency shelters increased by 16 percent and the number of homeless adults living in transitional housing rose by 9 percent (Wilder, 2009).

For the purposes of this study and in keeping with their past research studies, Wilder continues to use the Department of Housing and Urban Development's (HUD) definition of homeless. Therefore, a homeless person is anyone who (1) lacks a permanent, regular and sufficient nighttime residence; or (2) has a primary nighttime residence that is a temporary living accommodation, such as an emergency shelter, transitional housing or battered women's shelter; or (3) has a nighttime residence that is unacceptable for human habitation, such as cars or under bridges (Wilder, 2009). The research aims to explore the variables that contribute to adult homelessness.

Mental illness appears to be a major factor contributing to the number of homeless adults in Minnesota. The Wilder study discovered that 59% of adults in Minnesota who reported being homeless for one year have a serious mental illness, while 46% of those who reported being homeless for one month, have a serious mental illness. Of the 59% of adults who reported having a serious mental illness, 72% of them reported

being diagnosed with a Severe and Persistent Mental Illness (SPMI), (Wilder, 2009). The National Alliance on Mental Illness (NAMI) defines mental illness as a medical condition which disrupts a person's thinking, mood, feeling, ability to relate to others and daily functioning (NAMI, 2013). NAMI identifies those who have a serious and persistent mental illness as having any one of the following diagnosis: major depression, schizophrenia, bipolar disorder and borderline personality disorder. While mental illness is a factor in adult homelessness in Minnesota, it appears to be a factor on a national level as well.

According to Torrey (2008), research indicates that historically, persons with a mental illness were treated inhumanely. As a result, new laws aimed at humanizing persons with a mental illness were passed as well as new medications and research, which prompted a wave of deinstitutionalization of persons with mental illness from inpatient psychiatric units. At the same time, activists pushed for changes in commitment laws, which made it more challenging to treat patients that left the hospital. All of these factors contributed to a rise in adult homelessness in persons with a mental illness.

One response to the rise in homeless adults with a mental illness is Group Homes/Adult Foster Care facilities. The Minnesota Department of Human Services accepts and licenses a variety of facilities used to house homeless adults with a mental illness. These include: Group Homes; Nursing Homes; Certified Boarding Care Homes; Noncertified Boarding Care Homes; Supervised Living Facilities; Board and Lodging Facilities With Special Services; Board and Lodging Facilities; Adult Foster Care Homes and Assisted Living (DHS, 2010). For the focus of this study, only the independent Group Home/Adult Foster Care model was considered. It is important that attention is

paid to the historical effects of deinstitutionalization of people with a mental illness and the affect it has had in creating a huge adult homeless problem for people diagnosed with a SPMI. Research shows that in 1955, there were over 558,000 people with a mental illness in public hospitals. However, according to Torrey, as a result of deinstitutionalization, only 40,000 people with a mental illness were in public mental hospitals in 2006 (Torrey, 2008).

Social workers play a key role in assisting adult homeless individuals diagnosed with a SPMI. Social workers are often the first point of contact for people needing assistance as they work in hospitals, homeless shelters, social service agencies and non profits. According to Sun (2012), in 2008 there were 642,000 positions held by social workers in the United States. Of that 642,000, social workers who were most likely to encounter homeless clients worked in the mental health field, mental health and substance abuse field and public health (Sun, 2012). Therefore, it is imperative that social workers become knowledgeable about deinstitutionalization as well as the responses that were created to try to remedy the problem. Further research is needed to be able to assist social workers in identifying the most beneficial housing opportunities for adult clients who are homeless and mentally ill.

The purpose of this study is to examine the strengths and limitations of the Group Home model for adult people who are homeless and mentally ill. With this information, future social workers will be more effective in advocating for their clients housing needs. Additionally, social workers will be more knowledgeable about the history of the problem, which will make them more effective in advocating for social policy changes for adult homeless people with a mental illness. The research question will be answered

through qualitative interviews with people who own Group Homes that serve adults who have a mental illness and who have experienced or have been at risk of homelessness.

Literature Review

Homelessness for people diagnosed with a Severe and Persistent Mental Illness (SPMI), can be attributed to many variables. Furthermore, the individual Group Home/Adult Foster Care model is set up to be flexible in addressing those variables. The goal of this research is to identify those variables, while also examining the individual Group Home/Adult Foster Care model's effectiveness in serving adult homeless clients who have a SPMI. The main topics that will be discussed in this section are: national homeless statistics; Co-Occurring Disorders; Racial Disparities, History of Deinstitutionalization and a critique of the individual Group Home/Adult Foster Care model.

National Homeless Statistics

According to a study by the National Coalition for the Homeless in 2011, there were 636, 077 homeless people in America. Additionally, they estimate that approximately 40% of adults in the homeless population have a disability (NCH, 2011). Research conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates on any given night in 2010, 26.2% of all sheltered persons who were identified as homeless had a severe mental illness (SAMHSA, 2010). Thus, the research intends to identify the variables that have contributed to the rise in adult homelessness in people diagnosed with a SPMI.

Variables Contributing to Homelessness in Adults with a SPMI

According to Drake (2009), individuals with co-occurring substance abuse and severe mental illnesses are more susceptible to negative outcomes such as homelessness,

poorer psychosocial adjustment and higher rates of re-hospitalization. Additionally, studies show that when individuals with co-occurring substance abuse and severe mental illness obtain stable housing, it is often a substance abuse relapse that causes them to become homeless again. As a result of numerous evictions, it is more challenging to find suitable housing that will be accepting of their housing record. However, the lack of available housing forces homeless adults with a mental illness to seek out shelters. The downside of shelters for these individuals is that they are overcrowded, noisy and therefore, exacerbate negative symptoms of psychosis. Some negative symptoms include: restrictions in range and intensity of emotional expression, restrictions in fluency of thought and speech and restrictions in initiating goal directed behavior (DSM-IV-TR, 2000). This leads many individuals to seek out inpatient hospitalization for their temporary shelter needs (Drake, 2009).

Shortage of Public Psychiatric Beds for People with Mental Illness

According to a survey conducted by the Center for Mental Health Services (2005), in 1955 the Unites States population was 164.3 million and there were 558,239 public (state and county) psychiatric beds available to individuals who were mentally ill. Thus, the availability of public psychiatric beds was 340 beds per 100,000 people. In 2005, there were 52,539 public (state and county) psychiatric beds available to individuals who were mentally ill. However, the population of the United States grew to 269.4 million in 2005. Therefore, the number of available psychiatric beds dropped to 17 beds per 100,000 people. The study concluded that 95 percent of the psychiatric beds that were available in 1955 were no longer available by 2005.

Racial Disparities

The Wilder research study found that significant racial disparities exist among homeless adults in Minnesota. For example, African-American and African born people constitute about 4 percent of the adult population in Minnesota. However, they represent 41 percent of Minnesota's homeless adult population. Similarly, American Indians represent 1 percent of the adult population in Minnesota, while they account for eleven percent of the homeless adult population. In comparison, whites make up 90 percent of the adult population in Minnesota, but account for less than 40 percent of the homeless population (Wilder, 2009). According to Uehara (1994), research indicates that unlike ethnic Whites, Asians or Latinos, African Americans continue to face high levels of housing discrimination based on their race. This disparity persists in both the rental and purchase market. Uehara (1994), also found that due to the significance of race as a determining factor in homelessness, African Americans with a SPMI are more likely than Whites and other ethnic groups to live in substandard or low quality housing.

History of Deinstitutionalization

According to Torrey (2008), historically, mental illness was considered to be a state issue and people who were diagnosed with a SPMI were institutionalized in state mental hospitals with little to no individual attention to their specific condition. However, in 1946, Harry Truman faced mounting pressure from lobbyists to make mental health a federal issue. Truman passed the National Mental Health Act, which eventually established the National Institute of Mental Health in 1949 (Torrey, 2008). Additionally, in 1963, congress passed the Mental Retardation Facilities and Community Health

Centers Construction Act, which provided money to develop a network of community mental health centers throughout the United States (National Archives, 2012). However, the money was not always spent in the best way as there was no organization or guidelines as to the most effective way to treat persons with mental illness. The consequences of deinstitutionalization resulted in a sharp rise of persons with mental illness becoming homeless (Torrey, 2008). In 1999, the United States Supreme Court passed the Olmstead decision, which charged that unnecessary or unwanted institutionalization is discrimination for persons with a mental illness or disability. Additionally, the Olmstead decision found that institutionalizing people with mental illness isolated them from their families, friends, and autonomy. Therefore, Olmstead required people with mental illness to be placed in the least restrictive environments (Bartles, Miles & Dums and Levine, 2003). Some of the least restricted environments include: integrating into the community; living in group homes; foster care facilities; assisted living and supportive housing communities. Currently, the struggle to serve persons with mental illness who are also homeless is mounting. Many states responded to deinstitutionalization by authorizing licensing of private Group Homes/Adult Foster Care for the purpose of satisfying the requirements set out in the Olmstead decision (Riley, 2011).

Consequences of Deinstitutionalization

According to Torrey (2008), deinstitutionalization and the decrease of available psychiatric beds has consequences for people with mental illness as well as for the communities they live in. Some of the consequences include: increased homelessness; emergency rooms being flooded with patients waiting for a psychiatric bed; homeless

shelters filled to capacity; incarceration of people with a mental illness in prisons and jails and an increase in violent behavior, including homicides, in communities across the nation.

Financial Impact of Homelessness

In a comparison study conducted by the Economic Roundtable (2009), of the costs associated with supported housing versus homeless, researchers found that public costs decrease when individuals are no longer homeless. The study examined 10,193 homeless individuals in Los Angeles County in which 9,186 continued to experience homelessness while receiving general public assistance and 1,007 exited homeless by entering supportive housing. Researchers found that when chronically homeless disabled individuals secured supportive housing, public costs decreased by 79 percent. Additionally, public costs decreased by 50 percent for the entire population of homeless public assistance recipients when individuals moved temporarily or permanently out of homelessness. Also, public costs decreased 19 percent for individuals with serious problems such as, jail histories, mental health issues and substance abuse issues who only received minimal assistance in the form of temporary housing. Researchers also found that the average high cost for one homeless man who is mentally ill, on public assistance, experienced hospitalization or has been incarcerated and on probation is approximately $4,739 per month. However, the typical public costs for a homeless man is $2,897 per month, while the public cost for an individual who receives supportive housing is $605 per month Economic Roundtable (2009).

Group Homes/Adult Foster Care Facilities as an Intervention

Group Homes/Adult Foster Care is an effective intervention in caring for homeless persons with a mental illness. They are based in local communities and qualify under Olmstead as least restrictive environments (Riley, 2011). According to the Minnesota Department of Human Services, Group Homes/Adult Foster Care "provide supervision, counseling, and DHS-licensed habilitative or rehabilitative program services." In 2011, DHS reports that the Group Home/Adult Foster Care program served a monthly average of 18,200 disabled and elderly. There are currently 6,111 licensed or registered settings in Minnesota, with 4,373 of these being Adult Foster Care Homes. According to the DHS (2009), research indicates that as of 2009, there were 89 licensed Group Home facilities in Minnesota. In addition, those 89 Group Homes provided 3,161 beds.

Types of Group Homes/Adult Foster Care Facilities

The Minnesota Department of Human Services uses the name Group Homes/Adult Foster Care Facility and Assisted Living interchangeably to describe the same model. The Individual Group Home/Adult Foster Care Model is a home that provides sleeping accommodations and services for one to five adults or more and is licensed by the Minnesota Department of Human Services. The rooms may be shared or private and the dining areas, bathrooms and other spaces are shared family style. Group Homes/Adult foster care homes can offer a wide array of services. There are two types of group homes/adult foster care: family adult foster care and corporate adult foster care. In family adult foster care, the license holder lives in the home and is the primary caregiver.

In the corporate adult foster care, the license holder does not live in the home and is not the primary caregiver. Instead, trained and hired staff members provide services to clients. These types of homes serve people who are chemically dependent, mentally ill, physically disabled, and developmentally disabled DHS (2009).

Board and Lodge vary greatly in size, with some resembling small homes and others are similar to apartment buildings. They are licensed by the Minnesota Department of Health (or local health department). Board and lodges provide sleeping accommodations and meals to five or more adults for a period of one week or more. They offer private or shared rooms with an attached or in some cases, a private bathroom. There are common areas for dining and for group activities. Many offer a variety of supportive services, including laundry or housekeeping as well as home care services such as, assistance with bathing or medication administration to residents DHS (2009).

Boarding Care homes are licensed by the Minnesota Department of Health and are homes for persons needing minimal nursing care. They provide personal or custodial care and related services and typically serve five or more older adults or people with disabilities. They have private or shared rooms with a private or attached bathroom. There are also common areas for dining and for other activities DHS (2009).

Social Worker Role in Group Home

According to Schneider (2010), social workers play an important role in working in group homes. They can be there to supervise from 8 to 24 hours per day. They can provide assistance in educating clients about their symptoms and their prescribed medications. Social workers can facilitate social gatherings for clients to participate in

and can be a mediator for clients when they are disagreeing with one another. Social workers can assess clients and refer them to service providers in the community. They can also monitor and report on their clients symptoms. Finally, they can intervene when a client is having a psychiatric emergency.

Strengths of the Group Home Model

According to Tsai (2010), providing housing to adult people who are homeless and mentally ill increases their level of overall hope. Hope can be defined as "having a sense of agency over one's desired goals and positive feelings about one's ability to reach those goals" (Tsai, 2010). Tsai's research examined 89 clients who lived in a residential program to that of 160 clients who lived in independent housing, such as an apartment. Tsai found no significant differences between clients level of hope based on their housing situation. However, there was a significant difference in level of hope based on age and number of lifetime hospitalizations. For example, clients who are older and have experienced more lifetime hospitalizations reported feeling lower levels of hope (Tsai, 2010).

Similarly, in a comparative evaluation of supportive apartments (SA), group homes (GH) and board and care homes (BCH) for clients who are mentally ill, Nelson, Hall and Walsh-Bowers (1997) discovered that residents of BCH as well as GH reported feeling more support from staff than did residents who lived in SA. They reported receiving assistance from staff in coordinating their care, reminding them about their appointments and monitoring their progress. Additionally, more clients who lived in SA reported that their relationships with their living companions had deteriorated, than

clients who lived in BCH and GH. However, more than half of the residents in all three living situations reported that there living situation had improved their mental and physical health. They also reported that their housing situation: promoted their independence, growth, ability to cope with life stressors and social skills (Nelson, Hall & Walsh-Bowers, 1997).

Housing Worthiness

According to Schneider (2010), written and spoken language is used to group potential residents into categories to determine their eligibility for housing. This study examined group homes with high support, where support staff are present from as little as 8 hours, to as much as 24 hours. Schneider (2010) found that supportive housing agency representatives are flexible in their use of language in determining worthiness for admission to their housing program. For example, one criteria of worthiness is the client's medication compliance, which is central to clients being able to obtain housing. However, not all clients are compliant due to the medication not working or voluntary stoppage due to adverse side effects such as profuse sweating and vomiting. Schneider (2010) discovered that when an agency representative inquired about a clients medication compliance in determining whether the client would be accepted into their housing, they allowed for flexibility if the client demonstrated that they are willing to talk to their doctor about their issues with their medications, versus refusing to take them at all.

Schneider (2010) also found that another criteria for worthiness of housing is a clients history of violent behavior. The study revealed that agency representatives were more flexible in allowing for violent behavior if it was the result of the client having a

psychotic episode. These episodes were viewed by agency representatives as being in alignment with the clients symptoms and therefore, were viewed as more acceptable than if the client did not have a mental illness. This flexibility in language allowed more clients to be admitted into supportive housing than would have otherwise (Schneider, 2010).

The last criteria in determining housing worthiness is active versus treated chemical addictions. Schneider (2010) discovered that clients who were actively using were denied housing. However, clients who were seeking or participating in some type of chemical dependency treatment as well as some period of non-use were deemed eligible for their housing (Schneider, 2010). All of this suggests that even with a set of standards to determine housing worthiness, representatives of housing agencies demonstrate flexibility in the language in which they describe a clients improved functioning. Through the use of flexible language, agency representatives are able to circumvent the rigid rules to allow clients access to their housing (Schneider, 2010).

Critique of the Group Home Model

According to Riley (2011), though Group Homes provide a shelter option for people who are homeless and mentally ill, many operate similar to institutions. Riley (2011) contends that many individual Group Homes are privately owned and operated for profit facilities that provide little oversight from government entities in how the day to day operations are executed. This minimal government oversight often leaves people who are mentally ill and vulnerable to the mercy of some owners who are in the business to make money. Additionally, many Group Homes operate similar to the institutions they

were intended to replace. According to Riley (2011), a New York State policy of licensing private group homes was challenged in a district court case which involved *Disability Advocates v. Paterson*. Disability Advocates, an advocacy organization for the mentally disabled recalled evidence from an investigation that personal care attendants at a group home were instructing residents in what to do throughout the day, including: when to eat; bathe and take medications. Additionally, Disability Advocates found that most Group Homes were restrictive in that they have curfews, visiting hours and require visitors to sign in and out when visiting a resident and do not allow overnight visits (Riley, 2011).

Riley (2011) discusses another limitation of Group Homes is that they are in many cases located in segregated suburban or rural areas that do not have adequate public transportation, which can cause clients to become isolated to the town in which the group home is located. Furthermore, Riley (2011) cites that the court found that individuals are often confined in close quarters with other residents who have a mental illness. This may encourage clients who are symptomatic to isolate and disconnect from the community in which they live. Riley (2011) found that the goal of the Paterson case was to further the cause of client access to supportive housing in which the client would live independently in their own housing such as an apartment, but continue to have access to supportive services through case managers, Assertive Community Treatment (ACT) teams and Independent Living Skills (ILS) workers.

Group Home Model with Supportive Services

According to a study by Kreindler-DPhil and Coodin (2010), while group homes and supportive housing provide shelter to people who are homeless and suffer from a mental illness, a clients residential stability increases when they are involved with outside intensive case management or an Assertive Community Treatment (ACT) team. Their research shows that client participation with one of these outside services increased their ability to locate housing soon after beginning with the programs. They also found that housing instability decreased dramatically after 6 months of client participation with intensive case management or an ACT team. Additionally, Kreindler-DPhil and Coodin (2010), discovered that in addition to participation in an ACT team or intensive case management, greater residential stability was achieved when rental subsidies were offered. This implies that providing supportive housing alone to clients is not enough to prevent future homelessness.

Predictors of Housing Instability

Kreindler-DPhil and Coodin (2010) found that substance abuse by clients proved to be the greatest impact on their housing instability, increasing it more than “2-fold.” This was the case even when clients participated in an Assertive Community Treatment (ACT) team or intensive case management. While substance abuse appeared to be the greatest predictor in housing instability, Kreindler-DPhil and Coodin (2010) found that housing instability decreased by 50% for clients who lived in their own independent housing, with supportive services.

Summary

Consequences of deinstitutionalization led to a rise in homelessness for people with a Severe and Persistent Mental Illness (SPMI). Group homes are an effective intervention in providing housing to those who would otherwise be hospitalized or homeless. The family foster care and corporate adult foster care group home model was the focus of this study**.** A comparative evaluation of supportive apartments, group homes, board and care homes and housing factors of housing worthiness were contributing strengths of the group home model. Some group home model limitations include: they resemble institutions, are often located in segregated neighborhoods, they lack supportive services and substance abuse issues continue to be factor in housing stability. Also important to keep in mind are the statistics on the homeless population. In 2011, there were 636, 077 homeless people in America, while approximately 40% of adults in the homeless population have a disability. On any given night in 2010, 26.2% of all sheltered persons who were identified as homeless had a severe mental illness. All of the variables previously discussed play an important role in determining the most appropriate housing for people who have experienced homelessness and who have mental illness.

Conceptual Framework

Framework Chosen and Explanation

The framework that was chosen for this research was the ecological model. This model was chosen because it provides a variety of options for social workers to intervene with the multiple systems that impact the group home setting and the clients that reside there. Forte (2007) describes the ecological model as the examination of relationships between human beings and their physical and social environments. The ecological model provides social workers with a framework that encourages them to collaborate with their clients to engage them with their family, social, community and governmental environments. According to Cohen (1989), "the engagement phase in practice with homeless mentally ill clients is central to work with this vulnerable population" (p.1). This is important when examining persons with mental illness and housing opportunities, because often people who are homeless and mentally ill have experienced unpredictability with their family, friends, housing situations and service providers.

Furthermore, the ecological perspective not only promotes collaboration, but it stresses the need for social workers to have a breadth and in depth knowledge of the many systems clients participate in. Some of these systems include: social security disability; public assistance; pharmacies; hospitals; psychiatric and therapeutic service providers. These systems not only impact group homes, but also the clients that reside in them. Social workers who learn about the various systems, community resources and service providers are more flexible, which enables them to intervene at the stage of change that the client is at in any particular moment (Cohen, 1989).

Key Concepts

The ecological model provides a wide scope by which to view the problem and includes six key concepts; micro-system, meso-system, macro system, adaptation, transaction and goodness of fit. However, for the purposes of this study, only four of these concepts were used to generate interview questions.

Micro-systems take into account the person in their environment (Forte, 2007). In this particular research, the micro-system of the individuals being studied was the impact of the group home on the individual client.

Meso-systems addresses the connections between the individual and two or more settings (Forte, 2007). In this particular research, the setting could be working on their social relationships in their group home, while participating in group therapy treatment in a day treatment program. This would also encompass group home staff interactions with other systems the client is engaged in such as employment, social and mental health services.

Macro-systems looks at the patterns of cultures in an expanded social context (Forte, 2007). This research attempted to look at different cultural or religious values or beliefs in relation to the appropriate fit for a client in a group home. It also included looking at the stigma of mental illness in society and with group homes in the community.

Transaction looks at the degree to which there is match between the individual's current needs and assesses the quality of their environment over time. An example of this

would be on whether or not the group home is addressing the issues that each individual client presents versus focusing on one overreaching problem shared by multiple clients.

Strengths and Limitations of the Ecological Model

A strength that was available in adapting the ecological model to this research is that it can be applied to mental illness, homelessness or housing in conjunction with one another or as a separate entity. Second, it allows social workers to be flexible in working with clients in a particular area, while at the same time, taking into consideration and addressing other areas as well. A limitation that presents itself is that social workers may try to address too many concerns at one time, which could lead to burnout. Additionally, addressing too many issues at one time with a client could lead the client to feel overwhelmed and as a result, disengage with the social worker.

In this research, micro-systems, meso-systems, macro-systems and transaction were applied by examining the client's environment, how they function in group home and how the two influence each other. The framework being used in this research assisted the researcher in developing a set of interview questions for the qualitative interviews.

Methods

Research Design

The purpose of this study was to examine the problem of deinstitutionalizing people with a Severe and Persistent Mental Illness (SPMI) and to explore the benefits and challenges of group homes and adult foster care for people with a severe and persistent mental illness. Additionally, the interview questions focused on how well the group home model addresses the problem of homelessness that was caused by deinstitutionalization. The design that was used in this study is exploratory and qualitative. This particular research design was chosen because, in utilizing exploratory research, the respondents were not limited to specific answers, so they were able to expand on the questions being asked. The research is qualitative, because its' intent is hear first-hand from professionals most knowledgeable about the group home model and its impact on clients. The research focused on data about homelessness, mental illness and a critique of group homes/adult foster care facilities through qualitative interviews with group home and adult foster care facility owners that serve previously homeless clients diagnosed with a SPMI.

Sample

The potential respondents were to have owned a group home/adult foster care facility for at least five years or more in the Minneapolis-St. Paul metropolitan area. The potential respondents were to have experience providing housing and services to previously homeless clients who have a mental illness and clients who are at risk of

becoming homeless. Finally, the criteria was flexible in that potential respondents did not have to include those who were social workers.

Protection of Human Subjects

Potential participants were to be provided the consent form and questions prior to deciding to participate in the study or not. This project was reviewed by the academic Institutional Review Board. Confidentiality was to be maintained through the data collection process, with each case identified using a number system. No identifying information was to be used in the final paper or presentation.

Instrument

The questionnaire was set up to keep track of the participant's demographic data such as years of experience, gender, ethnicity and profession. The questions were reviewed by the research committee prior to the interviews to limit research bias and ensure appropriate content. Additionally, the topics covered included: both open ended and closed ended questions to ensure that the respondent data includes specific answers, while at the same time, providing the respondent with flexibility to expand to the open ended questions to satisfy the exploratory nature of this study.

Data Collection

The data was collected using the following steps:

1) Researcher obtained contact information from committee members of professionals who own their own group home or adult foster care facility.

2) Researcher sent an email to those contacts to inform them about the study and provide researchers contact information if they are willing to participate.

3) Researcher sent a follow up email to potential participants to inquire about any questions or concerns they may have and to ask them if they would like to participate in the study.

4) Researcher followed the emails up with a phone call to inquire about their willingness to participate in this study.

5) Researcher sent an email to two established contacts that researcher has worked with, informing them of the study and asking them if they would like to participate.

6) Researcher set up two interviews with contacts that researcher has worked with.

7) Researcher rescheduled the interviews when respondents canceled.

8) Respondents canceled and did not appear to want to reschedule.

Data Analysis

All collected data from the interviews were to be transcribed by the researcher and a content analysis was to be conducted for the researcher to look for codes and themes (Berg, 2009).

Researcher Bias

The researcher has bias concerning group homes that serve individuals who have experienced homelessness and are mentally ill because of case management experience in linking clients who are homeless and mentally ill to group homes. Additionally, the

researcher has experience in coordinating client care with their group home staff. A strength for the researcher in possessing this experience is that the researcher was sensitive to the key issues of homelessness, mental illness and the group home model. However, a weakness of the researcher's experience includes: perceptions and judgments gathered from client perspectives on their group home experience as well as the researcher's experience in collaborating with individual group homes on behalf of clients. Based on the researcher's experience working with individuals who have been homeless and are diagnosed with a mental illness, researcher anticipated finding a lack of case management services offered in the group home which has been proven to improve the clients overall mental stability as well as housing stability. Researcher also anticipated finding that some of the group home owners will have a social work background and some will not. These biases were addressed through committee members reviewing the interview questions to ensure that the questions are not too leading or narrow in focus.

Researcher expected to find strength in the group home model in that it provides housing to clients who would otherwise be institutionalized. Also, researcher expected to find strengths in the group home model in that many offer supportive services through staff who are trained to assist clients in improving their independent living skills, monitor their medications to improve mental stability and to coordinate their care by assisting clients in keeping track of their appointments on a bulletin board. However, researcher expected to find limitations in the group home model in that many group homes that researcher has encountered have a high turnover staff rate and often hire individuals who are not well trained in mental illness symptoms or with behaviors that arise from those symptoms.

Findings

Sample

A snowball technique was attempted in order to collect a sample for this research. Recruitment of the sample began in early February, 2013. Contacts were attempted with a total of 8 potential participants via telephone. An email was sent to committee members to obtain contact information of professionals who own their own group home or adult foster care facility. Researcher received a response from one committee member who provided contact information for one potential participant and a phone number to a county intake line for waivered services. Researcher attempted to contact the other committee member in order to obtain contacts, but there was no response. Researcher contacted the county intake line and obtained phone numbers of two contacts. Researcher contacted another county intake line and obtained phone numbers of three additional contacts. Researcher contacted three potential participants from researcher's personal list of contacts. When there was no response, researcher made a second attempt to contact potential participants one week later. Researcher was able to speak with two potential participants at this time. Researcher was not able to speak with the other two. However, researcher was able to speak with two more potential participants within three weeks of obtaining their contact information.

Of the eight potential participants, researcher was able to speak directly with four potential participants and upon their request, sent the consent form, demographic information and interview questions to them via fax. Researcher was able to schedule interviews with two contacts. However, one contact canceled the interview and did not

want to reschedule and the other contact canceled one time and rescheduled. This contact canceled a second time and did not demonstrate an interest in rescheduling. Researcher attempted to schedule interviews with the two contacts that requested the interview materials, but did not receive a call back. Therefore, researcher was not able to interview any participants for this study.

Discussion

Barriers to Recruitment

The purpose of this study was to explore the strengths and limitations of the group home model in addressing homelessness for people diagnosed with a mental illness. However, researcher encountered barriers in being able to obtain a sample. Discussion of the barriers that were encountered may be useful to future research of this topic. Additionally, a discussion of other researcher evaluations of this topic may be useful to future researchers.

Accessing Group Home Owners

Accessing group home owners was a barrier in attempting to gather a sample due to the lack of accessibility of group home owners. Researcher found that the group home owners that were contacted only worked in the office one day per week for 3-4 hours. A sample may have been able to be obtained if the criteria would have been expanded to include a multi-level perspective, interviewing the group home owner, the housing manager as well as the support staff. Researcher attempted to make contact with eight potential participants and was able to connect with four group home owners. Of the four contacted, researcher was able to schedule two interviews. Out of 8 contacts, two agreed to interviews then later declined. Researcher was unable to access further contacts, as a snowball sample relies on the first group of interviewees to obtain additional possible research subjects.

Mistrust

A second barrier was that two of the four contacts displayed skepticism or mistrust of the research study. They asked researcher questions about what kind of information researcher was looking to obtain, who researcher was going to share this information with and if the information would be kept confidential. They also asked researcher to fax them the consent form, demographic information as well as the questions. Researcher speculated that the potential participants were skeptical of the process for three reasons. One, none of the group home owners were social workers, so they may not have experience in completing a research project. Two, the potential participants may have been leery of confidential data being exposed to the public. Finally, the potential participants may have been fearful of the data exposing the faults or limitations of the group homes. Exposing their limitations could potentially impact the funding they receive from the county to operate their group home. This suggests that the group home owners may have felt vulnerable in having their group homes evaluated due to not knowing who would have access to the material and how the study would impact their group home.

Lack of Response from Committee Member

A third barrier in gathering a sample for this study was a lack of response from the researcher's committee member, which may have created a sampling limitation for the researcher. According to Uehara (1994), a sampling limitation has the potential to limit the results of a research study, which may affect the overall generalization of the results. A possible explanation for the committee member dropping out is a fear of lack

of confidentiality. The committee member owns her own group home and may have been fearful of the study exposing the weaknesses of the group home model, which may impact the funding streams from county agencies that assist group homes in taking care of its clients. This has the potential to impact her since she owns a group home.

Another possible reason that the committee member may have dropped out is that she is not a social worker. She may have felt less invested in the process due to not understanding the significance of the project and its impact on the social work profession. Typically, social workers have had to complete a research project and will have an understanding of its importance to the school, the community and to the students who are trying to complete their graduate program requirements.

Time Constraint

Another barrier that emerged in the research study was the time constraint for the study. This research study was a requirement of the University of St. Thomas, St. Catherine University Graduate School of Social Work program. Researcher was given an approval by the Internal Review Board to begin the research in February. Researcher had approximately two months to complete the research and to write up the findings. Due to the challenges in contacting potential participants, researcher simply ran out of time to continue trying to reach group home owners and to schedule interviews.

How Other Researchers Evaluated the Group Home Model

A comparison evaluation conducted by Nelson, Hall and Walsh-Bowers (1997) of supportive apartments, group homes and board and care homes for psychiatric consumer/survivors developed from two pilot studies, one of group homes and the other

of supportive apartments. The pilot studies allowed the researchers to develop relationships with the participants as well as the settings to determine important factors to study and to test out their procedures. They studied a total of 14 supportive housing programs, eight group homes and six supportive apartments, which were operated by eight different non-profit organizations. All of the data was collected from government funded supportive housing programs (Nelson, Hall and Walsh-Bowers, 1997).

Recruitment Process

According to Nelson, Hall and Walsh-Bowers (1997), researchers contacted staff from mental health agencies who provide supportive services to clients residing in the group homes. They explained the study and asked for their help in recruiting clients to participate in a qualitative study. The providers then met with their clients to explain the study and to ask them if they would like to participate in the qualitative interviews. Researchers did not go directly to the housing operators in their recruitment process. Researchers gave participants a letter that explained the study and asked them to sign a consent form if they agreed to participate. Participants were also asked to give their permission for the housing staff to provide information on their level of independent functioning. Participants were paid $10 for every interview they completed (Nelson, Hall and Walsh-Bowers 1997).

In contrast, Piat, Ricard, Sabetti & Beauvais (2007), conducted an exploratory qualitative study of values and qualities of being a good caregiver and helper for persons with a mental illness. The study included two adult foster homes that were supervised by two university-affiliated psychiatric hospitals which were mandated to provide

community-based housing for individuals who suffered from a mental illness. Caregiver's years of experience as well as the number of residents living in each home were factors in selecting a sample. Researchers wanted to obtain a variety of caregiver experiences related to the size of the foster home. In all, Piat, Ricard, Sabetti & Beauvais (2007), were able to interview twenty foster home caregivers for their study. Caregivers were divided on education level, years of experience, age and place of birth. Interview questions were developed from the research team as well as the multi-disciplinary team. The interviews were audio recorded and were 45-90 minutes in length. The questions were open ended in nature and participants were asked to complete a demographic questionnaire upon completing the interview. Interviews were conducted over the course of seven months.

Researcher Reaction

A reaction I found myself having during the research process was feeling incredibly frustrated that I was not able to get a response from my committee member about contacts. I also felt frustrated at not being able to connect with four of the eight contacts that I attempted to reach. This feeling of frustration continued to grow when I had two interviews scheduled and they canceled on me twice. I felt disappointed that I was not able to collect a sample for this project.

Limitations/Recommendations for Future Research

A major limitation to the research was that the researcher was not able to obtain a sample for this study due to the mistrust of the study. It is recommended that future

researchers consider an online anonymous survey to distribute to the group home owners. This may make them feel at ease in participating in the study.

Another limitation to this research is the lack of investment in the research process by the group home owners. The snowball sample relied on the committee members to provide contacts for the study. It is possible that if the committee members do not have an established connection with the group home owners, they will feel no obligation to assist the researcher. Additionally, the snowball sample relies on obtaining contacts from interviewees for potential research subject. Researcher was not able to obtain additional contacts due to cancelled interviews. It is recommended that future researchers ask their committee members if they have contacts in the field before choosing a snowball sample.

Another limitation of this study was the lack of accessibility of group home owners. For example, researcher set out to collect a sample from group home owners who have owned their home for five years or more; group home owners who serve clients who have a mental illness and group home owners who serve people who have experienced homelessness. This narrow focus made it difficult to connect with the contact to schedule an interview as the contacts working days and hours varied. It is recommended that future researchers broaden their criteria to include group home owners, housing managers and support staff in order to obtain a sample.

Another limitation is the lack of buy in to the program evaluation process by group home owners. They may not have been able to see the value in evaluating their

program. It is recommended that future researchers make sure to note the explicit benefits to group home owners for participating in a study such as this one.

A final limitation for this study was the language used in recruiting group home owners. For example, researcher did not provide explicit benefits to the group home owners for participating in this study. Researcher could have included the benefit and importance of evidence based practices and explained how this study examined the strengths and limitations of the group home model in addressing homelessness for people with a mental illness. Completion of the research in this study would have been beneficial to group home owners as they could compare what they are doing to what the evidence shows is effective. Second, researcher could have included the benefit of this research to group home owners with regards to county funding. Due to budget cuts by most county agencies, group home owners who assess their practices will have leverage in being able to demonstrate that they are using best practices for their clients. This may mean additional or continued funding for their group home, even during the county budget cut period.

Implications for Social Work

Gaining information on the strengths and limitations of group homes continues to be an important goal in our evidence based social environment. Obtaining information on the strengths and limitations of group homes is difficult. Further research may need to insure anonymity to get the needed information. Also, the sample may need to include group home staff from various group home models as well as creating an online survey for the participant's convenience.

Conclusion

The purpose of this study was to explore the group home model in its effectiveness as a solution to homelessness for people who have a mental illness. Key findings made in this study include: sample limitations based on having a snowball sample wherein the committee member provides contacts to the researcher. In this case, the sample was limited due to a committee member dropping out, which resulted in a limited amount of potential participants for researcher to contact. Also, the research was limited due to the type of criteria that was compiled. The criteria that was compiled included was too narrow of a focus for this topic. This narrow focus made it difficult to connect with the contact to schedule an interview as the contacts working days and hours varied.

A sample may have been able to be obtained if the criteria would have been broadened to include group home staff from a variety of the group home models. Developing an online survey may have increased the sample. For example, it would have addressed the limited available time the group home owners would have had to invest in the study. Instead of a one hour face to face interview, they would have been able to complete a quick survey. Also, making the online survey anonymous would have protected the identity of the group home owners. Finally, explicitly listing the benefits of program evaluation of group homes to the owners may have increased the sample size.

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Appendix A

Critique of Group Homes in Addressing Homelessness for People with Mental Illness

INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study Critiquing the Group Homes in Addressing Homelessness for People with Mental Illness. This study is being conducted by Brenda Blaisdell, a graduate student at St. Catherine University under the guidance of Dr. Michael Chovanec, a faculty member in the SCU/UST School of Social Work and a committee of two professionals from the community. You were selected as a possible participant in this research because you know my committee member and you own a group home. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this study is to discover the effectiveness of the group home/adult foster care model in addressing homelessness for people who have a mental illness. Approximately 6-8 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to 1) Fill out a demographic questionnaire prior to the interview, taking approximately 10 minutes to complete. 2) Scan the interview questions for comfortability in answering the questions.

3) Complete one in-person interview that will be audio recorded by researcher and will last 30-45 minutes 4) Provide the researcher with potential participants for this study; (this is optional) which will last 5-10 minutes. The time frame for participating in this study is approximately one hour and fifteen minutes.

Risks and Benefits of being in the study:

The study has no known risks.

There are no direct benefits to you for participating in this research study.

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one will be identified or identifiable.

I will keep the research results in a locked file cabinet in my home and only me and my advisor will have access to the records while I work on this project. I will finish analyzing the data by May 25, 2013. I will then destroy all original reports, audio tapes and identifying information that can be linked back to you.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

New Information:

If during course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings.

Contacts and questions:

If you have any questions, please feel free to contact me, Brenda Blaisdell, at 763-458-5515. You may ask questions now, or if you have any additional questions later, the faculty advisor, **Dr. Michael Chovanec at 651-690-8722** will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at

(651) 690-7739.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time.

____

I consent to participate in the study and I agree to be audio-taped.

____

Signature of Participant Date

____

Signature of Researcher Date

Appendix B

Critique of Group Homes in Addressing Homelessness for People with Mental Illness

Demographic Information

Please review and complete these questions before we meet and bring them with you to the interview.

Please Circle One

Years of experience owning a group home

a. 5 to 8 years
b. 8 to 11 years
c. 11 to 14 years
d. 15 years or more

Years of experience working with individuals who are mentally ill? ________

Years of experience working with individuals at risk of homelessness? ________

What percent of your residents are mentally ill and at risk of homelessness? ________

What is the current ethnic make-up of clients at this Group Home?
Caucasian ______
African-American ______
Native American ______
Other ______

College Degree:

a. Associates Degree
b. Bachelor of Arts
c. Masters Degree
d. Some to no college

Profession (license)

LICSW LGSW LMFT LAMFT MHC LP LPC LPCC PsyD
Other Professional __________

Interview Questions

1) How would you describe your facility? Ex: Adult Foster Home, Group Home?

2) How many clients are served at this location?

3) Tell me about a typical day for a client at your group home?

4) What is unique about your group home?

5) What are the benefits of your group home: (Please provide an example if possible)

    a. for the clients?

    b. for the staff?

    c. for the community?

6) What are the challenges of your group home: (Please provide an example if possible)

    a. for the clients?

    b. for the staff?

    c. for the community?

7) How do you address the challenges you mention above:

    a. for the clients?

    b. for the staff?

    c. for the community?

8) What are the other housing options available for those clients who are not successful in your facility?

9) Who oversees your facility and what has been your experience with that?

10) What policies do you have in place which supports both client needs and the liabilities of the Group Home?

11) Do you have anything else that you think might be useful for this study?