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Marie D. Hoff
Boise State University

Katherine H. Briar
Florida International University

Kristin Knighton
University of Washington

Angie Van Ry
Central Area Youth Association - Seattle, WA

To Survive And To Thrive: Integrating Services For The Homeless Mentally Ill

MARIE D. HOFF, MSW, PH.D.
Associate Professor
Boise State University

KATHERINE H. BRIAR, MSW, DSW
Professor
Florida International University

KRISTIN KNIGHTON, MSW
Doctoral Candidate
University of Washington

ANGIE VAN RY, MSW, PH.D.
Director, Homeless Teen Parent Program
Central Area Youth Association
Seattle, WA

An intervention research project with homeless, chronically mentally ill persons demonstrated that linking rehabilitation services, such as employment skills and psycho-social stabilization, with survival services promotes success in serving this population. The project confirmed the central role of case managers in promoting engagement with mental health services and re-integration into stable community living.

Various studies indicate the homeless are a heterogeneous population (Baxter & Hopper, 1982; Stoner, 1983; Kaufman, 1984; U.S. General Accounting Office, 1985, pp. 5–6; McChesney, 1988). A large proportion of the homeless are low-income people who are the victims of economic changes—lost jobs and rising housing costs. Another large proportion of the homeless, the subject of this report, are the chronically and severely mentally ill, who are victims of the failed de-institutionalization policy

of the last twenty years (Ibid). While the sheer loss of low-income housing stock is also a factor in the homelessness of the mentally ill, their situation appears to be more profoundly related to the lack of a planned, comprehensive system of services in the community (Bachrach, 1984; Crystal, 1984; Lamb, 1984; Stoner, 1984).

True, de-institutionalization has had the positive value of greater freedom and autonomy for many of the mentally ill. The minimal care and stimulation, and sometimes flagrant abuses in the state mental institutions, were legitimately criticized by advocates for the mentally ill. However, the development of bus and subway stations, streets and highway underpasses, doorways and cardboard boxes as "homes", along with the more humane societal response of emergency shelters for the homeless mentally ill, has led to the ironic observation that we are creating the phenomenon of "asylums without walls" (Lipton, Sabatini & Katz, 1983, p. 821).

Service Needs of the Homeless Mentally Ill

Their residential instability and alienation from society makes it extremely difficult to accurately assess the needs of the homeless mentally ill. Most of our knowledge of their characteristics and needs comes from service providers and researchers working directly in shelters, jails, hospital emergency rooms and other service programs (Lamb & Grant, 1982; Arce, et al. 1983; Crystal, 1984; Hagen, 1987). Nine such studies were commissioned by the National Institute of Mental Health (NIMH) in 1983–84 to address the service needs and the planning and delivery of services to the homeless, chronically mentally ill (Bachrach, 1984). From these sources a number of observations can be made about service needs:

1. Perhaps the most crucial resource needed to serve the homeless mentally ill is a core of people with the skills to reach out and establish rapport and communication with persons broken by psychosis, alienation, a sense of failure, and the stress of sheer physical survival (Larew, 1980; Lamb, 1984; Cohen, 1989; Blankertz, et al., 1990).

An example of aggressive outreach is provided by the interdisciplinary teams of Project HELP, who cruised Manhattan

in a van, to provide crisis medical and psychiatric services, on both voluntary and involuntary basis (Cohen, Putnam Sullivan, 1984). Drop-in centers are a service model which demonstrate that supportive and nurturing environments, responsive to their basic survival and socialization needs, will draw some of the homeless mentally ill voluntarily, and that they can be engaged in more substantial services, such as treatment and rehabilitation (Breton, 1984; Stoner, 1984; Cohen, 1989).

2. Beyond outreach, the homeless mentally ill need stable human relationships and skilled assistance to help them obtain other needed services and resources. The case management approach, using both professionals, paraprofessionals and volunteers, is rapidly expanding and the various models of case management are being assessed for effectiveness (Baker & Weiss, 1984; Rapp & Chamberlain, 1985; Fiorentine & Grusky, 1990).

3. Most obvious is a need for community-based, low-cost housing characterized by a range of choices and structures for people who may never cope entirely independently (Ball & Havassy, 1984; Lamb, 1984; McChesney, 1988). Much creativity and a determined commitment to funding will be needed to provide the "appropriately supportive and structured living arrangements" (Lamb, 1984, p. 900). The laws which restricted the use of involuntary commitment and conservatorship may need to be re-examined to mandate physical care and treatment to those who are clearly a danger to themselves and others in the community (Ibid.; American Psychiatric Association, 1984).

However, research on the homeless mentally ill also suggests that the validity of diagnosis is questionable when basic survival needs are unmet (Baxter & Hopper, 1982; Bean, Stefl & Howe, 1987). Rehabilitation models must address the needs for food, clothing, shelter and medical care.

4. The relationship between mental illness and crime presents many diagnostic and service challenges. Research indicates that mental illness, combined with drug and/or alcohol abuse may result in higher rates of arrest and jailing of the mentally ill (Blankertz et al., 1990); or the jails may sometimes be an easier mechanism of social control than hospitals (Lamb & Grant, 1982). Additionally, the mentally ill themselves report that sometimes they knowingly choose to commit a misdemeanor in order to get taken to jail, when hard-pressed

for a safe place to sleep (Ball & Havassy, 1984; Larew, 1980). Clearly, whatever the causal relationships, programs serving the homeless mentally ill need to develop policies and procedures responsive to the complications of their involvement with the criminal justice system.

The research on serving the homeless mentally ill agrees on the need for a flexible, comprehensive range of services. These services must be founded on meeting their basic physical survival needs, and include various kinds of support services which recognize the range of human need for economic security, psycho-social relationships and stimulating activity (Lipton, Sabatini and Katz, 1983; Ball & Havassy, 1984; Kaufman, 1984). Psychiatric treatment, devoid of substantial attention to these other needs, will not succeed with the homeless mentally ill.

In Bachrach's analysis of the 1983–84 NIMH studies on the homeless mentally ill, she indicated a wide range of remaining research questions. Among these were (a) whether specific kinds of services and styles of service delivery are attractive to individuals in subgroups of the population; and (b) what kind of specific case management approaches may enhance service delivery to this population (1984, p. 913)?

This article report the initial results of a demonstration service project in Seattle, Washington, testing the prospects for engaging the homeless mentally ill in the development of work and employment skills, through a program design which began by first addressing their basic needs for stable housing, food, medical and mental health care, and financial support.

An Innovative Service for Homeless Mentally Ill

Community Psychiatric Clinic, a community mental health center in Seattle, has developed a number of innovative programs to serve the chronically mentally ill. These include several supportive residential programs, a thrift shop operated by clients, a sheltered vocational training program, and a Jail Diversion Program (JDP) for mentally ill clients who have committed legal offenses.

In 1987, with NIMH funding assistance, Community Psychiatric Clinic developed a drop-in center to provide prevocational skill development for the homeless chronically mentally ill in downtown Seattle. The program, entitled CLEAN START, offers on-site basic hygiene facilities (shower and laundry), free breakfast and low-cost ($1.00) hot lunch and socialization activities (games, outings, singing, etc.). Case management services are provided by professionally trained staff, to assist participants to obtain stable housing, medical and psychiatric care, financial aid, protective payeeship[1] and other services as needed and requested. For those participants who voluntarily express interest, the staff work with them to assess their work potential, and develop with them an individualized plan of activities at the program site, through which to learn prevocational or work readiness skills.

The purposes of the demonstration phase of CLEAN START were (a) to determine whether to provision of services to meet basic human needs for food, hygiene and, social contact, in the informality of a drop-in center, would engage the homeless chronically mentally ill in mental health treatment and acceptance of case management services, and, (b) to determine the degree to which the homeless mentally ill could benefit from prevocational skills training, as a foundation for entry into sheltered vocational training.

Clients practiced prevocational skills by participating in operation of the program, that is, they entered into individualized agreements to assist with laundry, meal preparation, cleaning of kitchen and bathrooms and other tasks. Skills emphasized were basic work readiness attitudes and habits, such as coming on the right day at the right hour, developing rapport with others in working on a task, and increasing ability to follow directions and accept correction.

An important policy feature of CLEAN START is the commitment to serve clients with multiple problems and service needs, such as homelessness, mental illness, history of criminal offenses, drug and/or alcohol abuse. Many of the participants have experienced rejection from other programs which are not designed to address their many interrelated needs.

CLEAN START operates in a small, but pleasant store-front

location in a relatively quiet downtown Seattle neighborhood. Access to the program is enhanced by the free downtown bus transportation, a public service available to the general population.

Evaluation Methods

An evaluation component was included in the development of the CLEAN START project. The process evaluation had two objectives:

1. To do an exploratory assessment of client improvement in functioning as a result of the program; that is, to seek to answer Bachrach's (1984) question regarding what kind of specific approaches enhance service delivery to this population; and, 2. To conduct a client satisfaction assessment, to determine what program features attract and engage clients. This second objective also responds to Bachrach's (1984) question regarding specification of services attractive to subgroups in the population.

The study population consisted of 42 CLEAN START participants and 12 comparison group clients served by another case management program of the agency, namely The Jail Diversion Program (JDP) referred above. A frequent limitation of field evaluation is the infeasibility of random selection of cases, which was a factor in this study. Some CLEAN START participants had been initially enrolled in JDP, and had then been referred to CLEAN START, as the JDP case manager assessed their potential to benefit from the prevocational skills training.

Data for the evaluation were gathered from four sources:

1. Rating scales used by the program to assess entry (baseline) and post-treatment measures of client level of functioning with regard to personal hygiene, independent living skills, prevocational skills and psychological coping. These rating scales consisted of standard forms developed for agency-wide use. (See Table 2 for selected results on specific skills rated.);
2. Client satisfaction assessment, which consisted of in-person interviews with clients, using open-ended questions. Interviews

were conducted with thirty-two (32) CLEAN START participants, and six (6) of the twelve (12) JDP comparison group;
3. In-person interviews with case managers regarding client needs and progress, also using open-ended questions;
4. Participant observation by the research team in the daily program of CLEAN START to develop grounded understanding (Schatzman & Strauss, 1973) of client problems and progress. For example, members of the research team frequently participated with clients and staff in preparing, serving and eating daily lunch, which was usually a major activity of the day.

CLEAN START Participants

The forty-two (42) CLEAN START participants came from two sources:
1. Thirty (30) participants were referred by two community-based mental health treatment programs for the chronically mentally ill. One program specialized in serving persons with high involuntary hospitalization rates, while the second served persons with high jail recidivism rates (the JDP of Community Psychiatric Clinic); and,
2. Twelve (12) participants were homeless, mentally ill persons *not* receiving mental health services at the time of referral to CLEAN START. These 12 were referred by shelters, other social agencies, or by a friend who was already involved at CLEAN START.

Of the 42 CLEAN START participants, 36 were male and 6 were female. Median age was 32, with a range from 21 to 57. Ethnic identity included 12 African-American, 2 Hispanic, 2 Native American, 2 Asian and 24 White. Twenty-five (60%) were on protective payee status (See Footnote 1). As Table 1 displays, 95% (n=40) of the participants had histories of multiple, involuntary hospitalizations, and over 50% (n=21) had histories of one or more jailings, and unstable housing or homelessness prior to enrollment in a community-based treatment program. Seventy-nine percent (n=33) had also experienced previous outpatient mental health treatment, and 69% (n=29) had evident drug or alcohol abuse problems.

Interviews with case managers enriched the descriptive understanding of the characteristics of the participants. Case

Table 1

Comparison of Client Status at Baseline and at Six-Month Evaluation (N=42)

	Baseline		At Follow-up	
	#	%	#	%
Homeless or in emergency shelter	21	50[1]	4	10
Experienced psychiatric hospitalization	40	95[2]	6	14
Experienced out-patient mental health treatment	33	79[2]	N/A	N/A[4]
Substance abuse (drug and/or alcohol)	29	69[2]	18	43[5]
Experienced incarceration (one or more times)	21	50[2]	6	14[3]

[1]At baseline
[2]Prior to baseline
[3]Arrest warrants issued prior to baseline
[4]Not applicable. CLEAN START *is* an out-patient program.
[5]Not strictly comparable to baseline, as case managers also included "excessive" cigarette smoking in rating.

managers' knowledge of the clients' history was based on formal case records and on information shared by clients in the course of the case management relationship. Both the CLEAN START participants and the JDP comparison group came from family backgrounds of poverty, with related lack of medical and dental care. Family background also frequently included mental illness, substance abuse, physical violence, and frequent moves by military families. The case histories of their troubled lives revealed the frequent lack of social support to ameliorate situational crises, resulting in a downward spiral into chronic, dysfunctional behavior and subsequent hospitalization or imprisonment.

The case example of Gregory, a white man, portrays poignantly this pattern:

> Gregory's mother died when he was seven, after which he was cared for by his grandmother, until she too died when he was

fourteen. His father, a blue-collar worker, was beset by the demands of earning a living, and had not been much involved in his parenting. Neither personal supports, such as neighbors or other kin, nor social services supports, such as foster care or homemaker services were forthcoming. Virtually alone in the world, Gregory took to the road and ended up in a medium-security adult prison at the age of eighteen. Here, he developed a veneer of prison toughness. His case manager at the Jail Diversion Project was his first significant human relationship since his grandmother's death. This case manager supported Gregory's move to a program with more services by personally accompanying him on his first visit to CLEAN START.

Service Use and Client Progress

Over the six-month time-frame of the evaluation, the program provided an average of 31 lunches, 15 showers and 13 laundry loads *per day*. Table 2 reports selected results from rating scales completed by staff to assess client independent living skills and employment skills at baseline and again at completion of the six-month evaluation process. These scales indicate clients' progress on developing independent living skills (e.g. hygiene maintenance, budgeting of money, developing a hobby or personal interest), and their progress on employment skills (e.g. grooming, punctuality, cooperation, working independently). However, with the exception of grooming, the changes were not statistically significant when subjected to a Sign test.[2]

As displayed on Table 1, 50% (n=21) of participants were either homeless on the streets or living in emergency shelters when enrolling in the program. Of these, seventeen were stabilized in permanent housing at the end of the six-month evaluation time-frame. Participants also avoided re-incarceration, (those six who were jailed were summoned by warrants issued prior to enrollment in CLEAN START) and had a lower rate of re-hospitalization during their participation in CLEAN START.

Of the 42 participants, two (2) went on to enroll in a sheltered vocational training program. A case example illustrates the magnitude of needs and dysfunction which were addressed to achieve even this modest level of success:

John, a 43 year-old African American man, was also referred

Table 2

Client Progress on Skills Development (N=42)

	Baseline		At Six-Month Evaluation	
	#	%	#	%
Independent Living Skills[1]				
Maintains personal hygiene	27	64	27	64
Handles own money	15	35	16	35
Budgets money to last through the month	12	28	13	31
Regular exercise	26	62	25	59
Able to use public transportation	36	85	36	85
Has a hobby or personal interest	19	45	21	50
Able to use support groups	20	47	19	45
Employment skills[1]				
Work, Readiness				
— Punctuality	11	26	14	33
— Grooming	17	40	24	57*
Work Attitudes				
— Initiative	14	33	17	40
— Persistence with task	15	35	19	45
— Speed in task completion	12	28	23	54
Interpersonal Attitudes				
— Rapport with co-workers	19	45	24	57
— Rapport with supervisor	28	67	28	67
Work Performance				
— Productivity	15	35	13	31
— Able to work without close supervision	19	45	20	47

[1]Rated "usually" or "always" by case manager.

*P<.01 (one-tailed Sign test).

to CLEAN START by the JDP. He had been initially enrolled in the JDP in 1984, after his arrest for drinking in public and shoplifting. At that time he was living in an abandoned house with no medication or social support. Several jailings and hospitalizations ensued before he stabilized in the JDP. His case manager accompanied him three times to CLEAN START before he came independently. The CLEAN START male staff member engaged John in the kitchen, step-by-step teaching him the fundamentals of cooking and discussing the role of male chefs. Eventually John obtained living quarters with cooking facilities, and was able to prepare a meal for himself and his case manager. John graduated to Community Psychiatric Clinic's sheltered workshop, and from there went on to a job as a janitor at 16 hours a week, earning $3.35 an hour.

For many clients, unsubsidized, independent employment in non-sheltered work settings may not a realistic goal toward which to strive. Nevertheless, when asked in open-ended questions what features of CLEAN START they liked, they said they appreciated being *asked and expected* to join in the work of the drop-in center. Although client progress was not statistically significant, case manager reports indicated that most clients showed at least improvement in skills of daily living and in ability to contribute to program activities. The case examples of Terry illustrates the unique and difficult-to-quantify patterns of client improvement:

Terry, a white man, in his thirties, had lost his one-room apartment when he was unable to pay his rent after being robbed. He was homeless and sleeping at the airport when he first began attending CLEAN START. He did not graduate to vocational training, but after several months of regular attendance at CLEAN START he obtained stable housing and progressed to being able to assist another client, Tim, who was legally blind, to renew his monthly bus pass and to regularly obtain supplies from the local food bank.

Client Response to CLEAN START

The thirty-two participants who were interviewed were asked open-ended questions to elicit both their positive and negative reactions to the program. The responses shed light on their own perceptions of needs and illustrate which features of

the program attracted and engaged their regular participation. Analysis of client interviews indicated that they viewed the program as a normalization experience. For example, clients said they were relieved to shower in private, rather than "with other naked men, like in the army" at the shelters, or in the dangerous environs of Single Room Occupancy (SRO) hotels.

Clients said they were initially attracted by the private shower, the free laundry, the low-cost, tasty lunch, and the friendly caring staff. Thirty-one percent (n=10), of those who were personally interviewed attributed their return after the first visit to their case manager. Case review indicated that the majority of clients who successfully engaged in CLEAN START during the demonstration phase, were physically escorted and introduced to the program by their case managers from the referring program, to ease clients' anxiety about involvement in a new setting. This underscores the importance of "aggressive outreach" and the important human contact which case managers provide for the mentally ill who frequently lack family or friends to offer support or structure in their lives.

A client poem demonstrates the, emotional response to sensitive staff who convey a sense of personal caring:

SECOND CHANCE by _____

I came into their midst a total stranger
Up until that point in my life, nothing had no real meaning
But these two compassionate people _____ and _____ [staff]
pointed me in the direction
that my wandering soul had sought for so long
In return for their counsel and a way of keeping my dignity,
they give me a chance to work a little in a place
appropriately named, CLEAN START
They have given me the key that shall unlock my torment and
allow me a second chance.

They also perceived the available opportunity to move to a vocational training program motivated them to engage in the work of CLEAN START. The implication appears to be that they did not view the tasks at the program as "make-work", but as a foundation for serious work opportunities.

Another normalization feature which clients cited was the opportunity for safe social activities. Most shelters require residents to vacate the premises during the day, and most SRO housing is isolated, cramped, and without program activities. Forty-one percent (n=13) of the 32 personally interviewed, said they would be sitting isolated in a room, without the program. Clients also volunteered that they were more likely to abuse drugs or alcohol when they found themselves idle on the streets.

Client control over the terms of participation also contributed to their continuation in the program. Over 60% (n=20) of the interviewees felt they had a voice in the program operation, and over 88% (n=28) felt they had a choice of activities and level of participation. Over 80% (n=26) felt comfortable in discussing a problem about the program with staff. Participants appreciated the freedom to choose when to come, which activities to participate in, and the opportunity to start over each day with a "Clean Start" if they were occasionally asked to leave for disruptive behavior on a given day. Staff did not eject them from the program for relapses into anger, drinking or psychotic episodes.

In summary, clients based their positive evaluation of the program on the availability of basic survival services, the caring staff, and the opportunity for work and other meaningful activity. Clients' negative comments on the program appeared to reflect limitations due to funding levels, such as crowded conditions and not enough food. For some it was their only meal of the day.

Comparison Group

Six clients (five male, one female) and their case managers in the jail Diversion Program of Community Psychiatric Clinic were interviewed to illuminate why clients might not be attracted to a prevocational program. Clients in the in the JDP program were more stabilized in the community, that is, they had adequate housing, finances and psychiatric treatment after an average of two years case management services. Their case managers had attempted to refer them to CLEAN START

because they felt they could have benefitted from the prevocational services at CLEAN START. However, they rejected referral to CLEAN START. In interviews with the research team they stated they had already solved their on-going need for basic hygiene and food services through their participation in the JDP. From this finding we concluded basic survival services and treatment and training should be linked *within* programs, to engage various sub-populations among the homeless, chronically mentally ill.

For example, the comparison group clients at JDP also explicitly recognized CLEAN START as a mental health program, and said they were not mentally ill. They apparently preferred the offender label, and also stated they preferred to seek work through their own efforts. Case managers also assessed the comparison group as generally more deviant, and older, than those who successfully engaged at CLEAN START, indicating the supervisory features of the JDP may indeed have been the appropriate treatment for them.

Policy and Program Implications

This evaluation of a demonstration service program contributes toward answering Bachrach's research questions (see page 238), and suggests specific policy and program features:

1. Programs which include resources for meeting basic needs (housing, food, medical care, etc.) are more likely to succeed in engaging clients' participation in mental health treatment and other rehabilitative services. Maslow's insight that basic security is the vital foundation of self-actualization is valid even for those whose potential may seem relatively limited.

2. A continuum of mental health programs are needed to meet the varied needs, preferences and characteristics of the homeless mentally ill. For CLEAN START participants it had normalization features, while others who refused referral saw it as stigmatizing. Moreover, this research supports other studies which suggest women may be more at ease in gender-segregated programs (Stoner, 1983; Breton, 1984). As participant observers, we concluded that the six women who attended CLEAN START appeared more ill-at-ease and participated less

in conversation and activities than did the men. Both female and balanced-gender programs are desirable. Ethnic and racial identity issues are also salient to program design. Again, as participant observers, we concluded that minority clients appeared less comfortable in participating and in expressing themselves.

3. Programs will do better in engaging the mentally ill off the street if they are internally flexible and willing to accept persons with multiple problems, including criminal offenses. Narrow entry criteria or rigid behavior requirements will not entice the mentally ill voluntarily. Involuntary commitment is obviously a necessary policy option; but the test of success of a voluntary program may well be the client's steady return. It appears that a key element in the clients' positive assessment of CLEAN START was their active involvement in evaluating their own functioning level, and in setting up case management and treatment plans for themselves—being able to say what they needed and wanted. This finding supports previous research on effective clinical interventions, which asserted the importance of the clients' views of their situation (Ball & Havassy, 1984; Rapp & Chamberlain, 1985).

4. Social activities and work and employment opportunities can and should be an integral component of working with the mentally ill. This project demonstrated that persons with chronic and severe dysfunction can progress toward more independent living. However, dramatic changes may not be likely. Moreover, clients themselves recognized that their mental and emotional coping diminished when they lacked meaningful, structured activity. While homelessness may arise from the "complications" of mental illness, it is also true that the aimlessness and fight for survival on the streets also contribute to deterioration of mental and emotional functioning.

5. Other researchers have noted that drop-in centers and community mental health outreach teams frequently suffer from undertrained staff and offer only crisis intervention and referral (Benda, 1990, p. 57). CLEAN START was staffed by professionally trained, experienced case managers, which presumably contributed to their ability to engage and sustain therapeutic relationships with persons with multiple and severe problems in functioning.

This research did not set out to study case management per se. The case manager' role emerged, however, as a critical variable in structuring and sustaining each participant's engagement in the program services. Appropriate topics for further research would include refinements on understanding the case management model and factors affecting case management performance and stability, as a basis for successful relationships to clients.

6. The family and personal histories of the homeless mentally ill, as recounted by case managers at CLEAN START and JDP, and illustrated by the case examples of Gregory, John and Terry, indicate that at least some chronic mental illness stems from unameliorated situational crises, rather than from organic factors. Crisis intervention services, and preventive social support systems are needed for individuals and families lacking natural helping networks of family and friends, to prevent the long and painful drift into the status of homeless, chronically mentally ill.

Notes

1. Protective payee status is a court-ordered status whereby a person's income is managed by a court-assigned party, when the payee is declared unable to appropriately use his/her own income. Skid Road alcoholics are frequently assigned to protective payee status to prevent their use of income to purchase alcohol.
2. The Sign test is a nonparametric procedure used to compare observations for small samples with ordinal measures, where a normal distribution cannot be assumed (Ferguson, 1981, pp. 400-402).

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