Time-Limited Assertive Social Construction:

A program for the prevention of homelessness for individuals with severe mental illness

Christopher Boyd

Portland State University, Department of Psychology

In fulfillment of the University Honors baccalaureate requirements

Acknowledgements

I must first and foremost thank my thesis advisor, Dr. Eric Mankowski, for his insight and expertise on this project. His willingness to commit to advising an undergraduate student with whom he had no previous contact speaks volumes. In his limited time and comments he made great improvements to this thesis, and for that I am in his debt. I would also like to thank the University Honors program at Portland State University for the excellent work that I have been privileged to be a part of. In a short four years, my abilities as a scholar have been refined in a way that could have taken decades to achieve on my own. Finally, I have to thank all of those who are in part responsible for my achievements in life so far; my family, my friends, my teachers.

Table of Contents

Abstract

Severe mental illness and homelessness has been subject to fierce debate over many of the elements involved, including the estimated rate of mental illness in the homeless population, the causes thereof, and the most effective solutions for such problems. This thesis identifies an estimate of the prevalence of severe mental illness in the homeless that was borne from a rigorous study of the general U.S. homeless population. This thesis challenges inaccurate beliefs about causality and provides social dysfunction as the primary cause of a remarkably increased risk of homelessness in the severe mental illness population. The Assertive Community Treatment and Critical Time Intervention programs have quite effectively addressed these social factors in the treatment of patients with severe mental illness, although the prevention of homelessness has not been their focus. The primary components of these two programs are used in the construction of a new program that will attempt to prevent homelessness in a potentially underserved portion of the severe mental illness population by means of building positive social networks.

Introduction

This work examines the disturbing prevalence of homelessness in American adults with severe mental illness (SMI). Current measures indicate a 6% prevalence of SMI in the general population, while the most accurate estimates of SMI in the homeless population ranges between 18-22% (Lehman & Cordray, 1993). Both the prevalence of SMI in the homeless, and the causes of such a great disparity in comparison to the general population have been the subject of intense debate between experts in the field of psychology, and a wide range of other disciplines including but not limited to economics, criminology, epidemiology, public administration and public health. Not surprisingly, there does not appear to be a single factor that determines the prevalence of SMI in the homeless, or conversely, the prevalence of homelessness in the SMI. A central goal of this thesis will therefore be to highlight the most significant and empirically supported cause of homelessness in the SMI population in order to design a rational and effective prevention program.

After a thorough discussion of the problem, the objective of this thesis will then be to craft a program for the prevention of homelessness in the SMI population that is based upon existing research. The program, which I have named Time-Limited Assertive Social Construction (TLASC), is designed to help individuals retain their residential stability, rather than regain it after they have already been institutionalized or rendered homeless. This relies upon social pressures to modify the behaviors of a patient, rather than providing additional medications or monetary interventions. TLASC is not meant to be a replacement for traditional therapy, but rather a supplement to it. The components of TLASC are derived from Assertive Community

Treatment and Critical Time Intervention, two well-established programs that work with this same population using similar methods, though the goal of said programs differ by degrees. Realistically, no program can prevent all of the various factors that lead to homelessness in any population, and this one will not attempt to do so. Instead, it will address the breakdown of social networks that seems to be one of the most crucial factors in the path to homelessness. It is hoped that the proposed program will be able to reduce the representation of the SMI population in the homeless in a manner that is financially feasible for wide-scale implementation

Severe Mental Illness and Homelessness It is necessary in this discussion to produce an exact definition for the term, severe mental illness. SMI is most commonly used to denote a condition that may be diagnosed as a severe and persistent Axis I disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), published by the American Psychological Association (APA) as a resource for practicing psychologists. For those unaccustomed to DSM jargon, this would include the kinds and types of diseases that are pejoratively characterized as causing 'crazy' behavior; schizophrenia, bipolar disorder, major depressive disorder, and obsessive-compulsive disorder make up some of the most common diagnosis that fall into the SMI category. It should be noted that the DSM-IV was published in 1995, and obviously this resource could not have been a source of reference for research before that date. Prior research used the DSM-III or the revised DSM-III-R in their definition of SMI. However, this does not greatly affect the issue at hand, as most of the contentious issues that were changed between editions (such as clinical diagnosis of homosexuality, pre-menstrual

dysphoric disorder and sexual orientation disturbance) were not major considerations in the research upon homelessness and SMI.

An additional definition that must be clarified is that of "homeless", a term that has been the source of conflict amongst studies over the years due to the financial and political capital that is at stake. The most restrictive definitions refer to what is commonly known as "street homelessness", in which an individual literally sleeps on the street or in other public places for a specified minimum amount of time. More liberal definitions include those who are at a high risk for street homelessness; those who live in Single Room Occupancies (SRO), motels, or stay temporarily with their friends. Though all of the variations of this definition include a population in earnest need, I believe that the more liberal definitions are frequently nebulous. For the purpose of clarity, and in order to be in line with the majority of studies on this subject, I will adopt the definition used by the Federal Task Force on Homelessness (1992), which defines a homeless person: as someone "who lacks a fixed, regular, and adequate nighttime residence" and someone whose primary nighttime residence is a "supervised public or private shelter designed to provide temporary living accommodations; an institution that provides temporary residence for individuals intended to be institutionalized; or a public place or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings."

It should be noted that in my research, the majority of data upon the homeless have not included youth, i.e. individuals under the age of 18, and it seems that this is something taken for granted in the community. Accordingly, use of the terms "homeless" or "homelessness" does not pertain to minors in this thesis. Justification for this restriction is discussed later in further detail.

Organization of Thesis Before this work lays out any of its evidence or conclusions, I believe it is necessary to explain to the reader the reasoning behind the structure so that they may understand the intentions of this work more clearly. In response to increasing resentment towards the detached nature of psychological research, the APA created the Task Force on Psychology and Public Policy, which was "charged with examining ways to increase the involvement, awareness, knowledge, and education of psychologists in the public policy process" (Federal Task Force on Psychology and Public Policy, 1986). As part of their efforts, their summary report included a description of the public policy process, broken down into five steps: (1) problem identification and definition; (2) program formation; (3) policy adoption; (4) policy implementation; (5) policy impact. As a preemptive caveat, they concede that the policy process does not necessarily proceed in this order, but rather that it generally follows this format with various recursive effects that would require a complex non-linear equation to adequately describe. However, an implication of the chosen order is that the ideal policy process would at least start at the first step and proceed from there, though this is not always the case. In order to cater this project of limited resources to a logical and manageable amount of work, I have chosen the first two steps of this process as the framework for my thesis, and will move through them in their respective order. The body of this work will be broken into two sections, named after their respective designation by the Task Force on Psychology and Public Policy.

In the first major section, titled "Problem Identification and Definition", I will review research on the prevalence of SMI in the homeless, and the effects that this has had upon the

population's mental health and overall quality of life. This section will then review research that attempts to identify the causes of homelessness in this population, and isolate the most pertinent variable for an intervention.

The second section of this thesis will focus upon solutions to homelessness in the SMI population by examining two existing programs. The first program, named Assertive Community Treatment (ACT), has a long history and a rich body of evidence to support its effects, and its uses have become widespread. The second program, named Critical Time Intervention (CTI), is a descendent of ACT that adopted new practices in order to specifically prevent homelessness rather than “revolving door” syndrome. The key elements of these programs will be knitted together in order to synthesize the framework for my TLASC program, which is designed to serve the SMI population in a new way. This program will be shown to target a population that has been previously underserved by this discourse community, and the implications of this will be discussed in greater detail. I will also call for more research in order to enhance the effects of the TLASC program.

Problem Identification and Definition

To appropriately address the first piece of the five-part policy process, this section will include a discussion of several aspects to the problem at hand. First, it will sort through current research in order to accurately quantify the prevalence of SMI in the homeless population, elucidating the need for concern due to a starling over representation. Next, this section will identify the effects of homelessness upon the SMI population in an effort to better understand the need for intervention. Finally, this section will dispel some inaccurate beliefs about the causes, and by extension possible solutions, of homelessness in this population, highlighting a breakdown in social networks as the most influential variable indicated by current research.

Prevalence of SMI in the homeless population Before one attempts to formulate a plan for the prevention of homelessness in a specific population, it is necessary to identify and quantify as accurately as possible the population that will be served. The need for accuracy is partially a political one, as an overestimate that is later discovered may undermine support for a program while an underestimate may result in later accusations of apathy and intentional underfunding to 'kill' an unwanted program. Additionally, a program itself may be particularly ineffective if it is only staffed to serve half of the targeted population. However, determining the prevalence of SMI in the homeless is incredibly challenging and confounding. Homeless individuals are difficult to track over long periods of time as they are prone to wander from place to place in response to the shifting availability of resources and pressures from local authorities. An additional confound is added when one attempts to accurately describe the portion of homeless

that suffer from SMI. Many of these individuals have only a tenuous grasp on reality at the best of times and are difficult to track using any sort of logically deduced method (Beicher, 1989). Even the most dedicated of organizations face severe difficulties in this task, such as the Federal Task Force on Homelessness and Severe Mental Illness; they wholeheartedly claimed in their 1992 publication, *Outcasts on Main Street*, that as many as a third of homeless individuals suffered from SMI, while alternative sources estimated that this number was almost a third less (Lehman & Cordray, 1993).

The disparate nature of these reports has not abated in the past two decades; the National Coalition for the Homeless and their report, *Mental Illness and Homelessness*, estimates a prevalence of SMI in the homeless between 20 and 25% (2009), while a contemporary study claims a much wider range of 20 to 35% (Coldwell & Bender, 2007). Clearly there have been great challenges in describing this problem, despite exhaustive efforts coupled with the best of intentions, or statistical shortcuts (Bassuk et al., 1984; Piliavin et al., 1989).

Despite difficulties in estimating SMI in the homeless, there does seem to be one study that was relatively effective in this task. In 1993, A.F. Lehman and D.S. Cordray conducted a meta-study to determine the actual prevalence of SMI in the homeless. This effort followed a precedent of studies on Alcohol, Drug, and Mental illness (ADM) diseases in the homeless community that had ascertained a widely varying rate of mental illness, ranging anywhere between 1% and 70% (Fischer & Breakey, 1991). The purpose of the study by Lehman & Cordray was to provide “more precise estimates for the prevalence of ADM disorders among the homeless”. Screening of these studies was performed using a strict set of criteria: (1) Focuses on

adults age 18 and older; (2) Sampled from settings not specifically targeting persons with ADM problems; (3) Utilizes a standard method for ascertaining the presence of an ADM disorder; (4) Presents original data on the prevalence of ADM problems. The criteria presented above are not explicitly justified by the two scholars, as they are meant to be taken as axiomatic. However, I would like to discuss these four points to justify these methods.

The first criterion may seem confusing as it completely eliminates a portion of the homeless population that is quite obviously affected by ADM disorders. Indeed, Lehman & Cordray have been fairly criticized on this point, as individuals under the age of 18 suffer from significantly less ADM disorders than the rest of the homeless population, and their exclusion causes the rate of these disorders to increase in their estimate (Draine, 2002). However, in the course of scholarly research, one must consider both the population that they are serving and the audience to which they are writing. The young homeless population is regarded as requiring a much more complex array of services due to problems such as custody issues, educational requirements, and alternative financial supports as many are ineligible for employment due to their status as a minor (Cuomo & Halala, 1998). Although still in need of further services, the need is very different from that of the adult population. It is not accurate to characterize the homeless population as including only those over 17 years old, but long-standing precedent has justified this practice in naming. If one wishes to address the population that is excluded by this definition, then they must use the term *youth homeless*. To some degree, this has created an esoteric understanding of modern research on homelessness, but realistic scholars hold to the practices of their community unless they wish to reinvent the wheel.

The second and third criteria were a matter of upholding empiricism as much as possible, due to the fact that many claims of rampant SMI in the homeless were determined to be the result of poor sampling methods. In one study which quite erroneously claimed that the vast majority of the homeless had a history of psychiatric hospitalization, the results were trumpeted across the nation in the form of newspaper articles and evening news-anchor headlines (Lipton et al., 1983). However, a cursory review of the contributing article by social scientists revealed that the sample population had actually been drawn from a pool of inpatients at Bellevue's psychiatric emergency services wing (Ropers, 1988).

The reasoning for the fourth and final criterion of Lehman and Cordray's study is perhaps the most self-evident, as it simply seeks to eliminate redundant data that could distort the final result. Instead of weighting data from multiple sources that may have varied in their rigor, the two scholars elected to use only the most methodical study of any particular population. The two authors achieved this by independently reviewing the abstracts of the studies which fit their criteria, and used a scoring rubric to rank their subjective quality (although the elements of said rubric are not discussed in the study). Lehman and Cordray then reviewed each article together to come to a consensus on the final rankings (1993).

The careful work done by Lehman & Cordray is evident, as their estimated range of SMI in the homeless is consistent with most contemporary measures of similar rigor (Bates & Toro, 1999; Kuno et al., 2000; National Coalition for the Homeless, 2009), and their study is still cited by more recent scholars (Draine et al., 2002; Coldwell & Bender, 2007). It should be noted that while scholars cite the study by Lehman & Cordray, many cite a range of SMI prevalence that is

significantly higher than that in the 1993 article. The upper limits of some ranges have drifted as high as 35% while still attempting to claim ties to the previous work. The disparity between these numbers is not explained, but this seems a particularly unlikely number when one considers that the meta-analysis was performed upon studies that excluded homeless families. This is significant in the study of SMI, as families are a sub-population that have lower rates of mental illness and therefore their exclusion from a set of data will drive the estimated rate of SMI higher in the remaining population (Draine, 2002). If anything, a more inclusive study of the homeless population would be likely to decrease the estimated rate of SMI. In order to avoid estimates that may be influenced by a particular climate of opinion, such as the growing belief that homelessness is not as strongly tied to economic conditions as once thought (Tompsett et al., 2006), my analysis will utilize the prevalence estimates of Lehman & Cordray, which puts the rate of SMI in the homeless between 18% and 22%, or more than three times the rate that is present in the general American population. While there is a great deal of debate over this number, I believe that this meta-analysis represents the most accurate measure to date.

One more caveat must be made for the estimate above. Lehman & Cordray's work is more-or-less an average of the studies conducted throughout the US, and does not necessarily reflect the prevalence of SMI in any one location. The two scholars discussed widely varying differences in the rate of SMI between localities as a possible explanation for the inconsistent results of studies throughout the US. Instead of describing a single location, they attempted to paint an accurate portrait of the entire US, at the cost of making the data less useful to any particular region. However, this thesis will attempt to construct a generalized program for the

prevention of homelessness, and so this average estimate is most appropriate for its intended broad application. It should be noted that during the implementation of the program, further research would need to be conducted upon local populations in order to make appropriate adjustments to funding and allocation of social resources.

Effects of homelessness on SMI populations It would seem simple enough to argue that homelessness causes significant damage to an individual and decreases their quality of life. This is not restricted to the many physical or pathological ailments that affect the homeless, as it is simple enough to imagine the kinds of effects that this strenuous condition could have upon one's mental state. However, when one approaches the subject with empirical intentions it becomes impossible to make assumptions in the typical way. As a necessary step in the justification of a homelessness prevention program for the SMI population, this section will discuss the impact of being homeless upon this group.

In 1995, Lehman et al. conducted a study to measure the impact of homelessness upon quality of life in the SMI population. Although this was not the first such study to conclude that homelessness has a negative impact upon quality of life, it was the first study to actually collect and analyze data with quality of life as a focus. The study compared two groups in the SMI population, one that was homeless and another that was not. Surveys of the two groups determined that both were similar in age, gender makeup, ethnic composition, and education. The quality of life data was collected via self-report surveys, and it was found that the homeless group received fewer resources from earned income, social security, Supplemental Security

Income (SSI), and social security disability insurance. The homeless did receive more benefits in the form of food stamps, social welfare, and veteran's benefits, although these did not make up for gap between the two. More conclusive were the data on self-reported satisfaction, which found that the homeless group was significantly less satisfied with daily activities, family contacts, and social contacts. While measures of material wealth are good indicators of how a person may feel, actual reports of dissatisfaction in this population serve as even stronger evidence that there is an adverse effect of homelessness on this group.

Another study conducted in Los Angeles from 1990 to 1991 also found that quality of life was lower for the homeless with SMI as compared to the rest of the homeless population (Sullivan et al., 2000). The study found that even though their sample of homeless with SMI received a greater amount of SSI, Social Security Disability Insurance, Veterans Affairs disability benefits, and Medicaid, they still reported higher rates of victimization and physical health problems, as well as a lower subjective quality of life.

SMI also has a significant impact upon the duration of homeless spells. One study found that psychiatric distress, as measured by the Brief Symptoms Inventory, was positively correlated to the median spell length of a period of homelessness (McBride et al., 1998). Individuals who scored the highest level of distress on this scale endured homeless spells that were more than twice as long on average as the individuals who scored the lowest This is an alarming association when one considers SMI individuals cycle in and out of homelessness more frequently than the rest of the at-risk population (2000). Not only do SMI individuals spend longer on the street, they do so more times in their life than the rest of those who experience homelessness.

Although one may be tempted to believe that these data shows the effect of actual psychiatric symptoms on housing stability, this is not the case. It is possible that the most distressed individuals have the most severe expression of psychiatric symptoms, but they may have lost housing stability because of underlying social factors that are associated. The symptoms of psychiatric disorders may be a symptom of an underlying problem that causes psychiatric distress as well as social dysfunction.

Even without being able to convincingly identify causality, evidence that more severe forms of SMI cause greater spells of homelessness justifies the need for social intervention in this population. Although defining a suitable scope for such a program has proven to be more difficult, the few studies above show that this population is suffering from their lack of residential stability, and that their psychiatric disorder is somehow related to this vulnerability.

Causes of homelessness in SMI populations If one were to form a homeless prevention plan using research conducted on the general homeless population, they may be tempted to label this problem as an economic one. They would certainly be correct in identifying economic supports such as SSI and single room occupancy (SRO) programs as the best method for helping the general homeless population. However, this program proposes to treat a different part of the population that experiences a different set of risk-factors.

Although SMI does not appear to be a primary cause of homelessness, the SMI population is shown to be at an increased risk for this condition (Lehman & Cordray, 1993). While there is need for economic and housing supports, research indicates that there are more

issues to be dealt with in order for this disparity to decrease. Two separate studies on the quality of life in SMI homeless populations found that the homeless SMI population drew more funds from public sources, and yet still suffered from a lower quality of life than the housed SMI population (Lehman et al., 1995; Sullivan et al., 2000). While public assistance is probably a necessary component to create residential stability, there are more issues that need to be addressed. There was a great deal of anticipation that the homeless population would swell with the ranks of the mentally ill during the 1960's as a wave a deinstitutionalization occurred in the United States. Increasing cuts were made to federal funding over the course of two decades, and many hospitals for individuals with mental illness were shut down without creating suitable discharge plans (Ropers, 1988). This may have been the cause of great exaggerations in the rates of mental illness in the homeless (Bassuk et al., 1984). As further cuts were made, even more institutions for the mentally ill were shut down during the Reagan administration (Ropers, 1988).

Despite predictions that deinstitutionalization would cause an enormous increase in the number of homeless mentally ill, later research found that there was no significant increase in homelessness during the 60's and 70's following the most extreme cuts to mental health institutions (Cohen & Thompson, 1992). Although detailed information upon the demographics of this population is unavailable, one would expect that if mental illness were a primary cause of homelessness, then this massive release of SMI patients into the streets would have caused a significant increase in the homeless population (Draine et al., 2002). A large increase in the number of homeless did occur in the 1980’s, however this cannot be definitively attributed to deinstitutionalization as there is no explanation for the twenty year lag between the largest

amount of deinstitutionalization and this increase in homelessness (Ropers, 1988). Some experts claim that this was not a sudden spike in homelessness due to SMI, but rather a general increase in homelessness due to economic conditions and a lack of affordable housing (Cohen & Thompson, 1992). Cohen and Thompson cite the loss of 30,000 SRO in New York from 1975-1981, giving weight to the argument that there was simply not enough low-income housing.

Why didn't the mentally ill end up on the street? One of the most surprising conclusions of mental health research is that psychiatric symptoms do not have a particularly strong effect upon residential stability. Intuitive reasoning may lead one to believe that the complications of mental illness cause homelessness. It was the belief of some scholars that alleviating the symptoms of an individual with SMI would help improve their residential stability (Beicher et al., 1989). It's possible that this assumption is derived from errant data that estimated an incredibly high prevalence of SMI (Lipton et al., 1983; Bassuk et al., 1984). However, studies have found that while a particular program, or variable within said program may have a strong effect on alleviating psychotic symptoms, this does not necessarily have a measurable effect on residential stability.

This is supported by a study that measured the effect of Assertive Community Treatment upon medication compliance in the homeless (Dixon et al., 1997). A result was that the medication compliance rate, which the study determined was inversely correlated with psychiatric symptoms, was not associated with any change in housing status. Two separate studies that interviewed homeless individuals, both with and without mental illness, asked the subjects what they believed were the primary reasons for their homelessness; the answers were

largely consistent with the conclusion of researchers in that mental illness was at best a secondary or tertiary cause, with a lack of social support during a period of unemployment or financial hardship being the primary perceived cause of homelessness (Roth & Bean, 1986; Mojtabai, 2005).

Research on social networks has found an inverse correlation between social network size and the symptoms of mental illness, with the most stable individuals being part of the largest networks (Bates & Toro, 1999). With this knowledge, it would seem like a worthwhile effort to expand the social networks of all mentally ill patients in order to alleviate their symptoms. However, multiple studies have found weak correlations between the expression of psychological symptoms and social support in this population (Bates & Toro, 1999; Trumbetta et al., 1999). The proposed reason for this phenomenon is that the symptoms of severe mental illness are much more biologically driven than those of less severe disorders, and are therefore less connected to exterior social conditions. It would appear that small social networks, SMI, and homelessness are all affected by social dysfunction.

A recent meta-analysis attempted to shed some light on the causes of homelessness in a portion of their study on social disadvantages in those with SMI (Draine et al, 2002). The article found that when SES was taken into account, data from several studies on SMI showed that there was no difference between the prevalence of SMI in the homeless and in the poor population (although this term is not defined). The similar over representation of mental illness in both the homeless and the poor led researchers to the conclusion that SMI is not a primary cause of homelessness, but more likely a primary cause of poverty and social disadvantage. This would

seem to hold true with the findings that decreasing the expression of psychiatric symptoms in this population does not have a reliable effect upon residential stability. Instead, one begins to see that the actual state having a SMI causes a breakdown in the social system that is analogous to that which is suffered by the impoverished portion of our population; psychiatric symptoms themselves seem to have a minimal effect.

The idea that a breakdown in social networks is a primary cause of homelessness in this population is further supported. Marriage is often considered by professionals as a proxy for social connections (Bates & Toro, 1999), and there is a large disparity in rates of marriage between the homeless SMI and the general homeless population. This has been a long supported fact, discovered during the first extensive studies of this demographic in the 80's, and reaffirmed a decade later (Ropers, 1988; Bates & Toro, 1999). There has also been a disparity in rates of marriage within the SMI population. Folsom et al. performed a massive study on over 10,000 psychiatric patients and found that while 14% of individuals with SMI and residential stability had ever been married, only 6.9% of those who were homeless with SMI had ever been married (2005). It is worth noting that even in the housed SMI population rates of marriage are extremely low compared to the rest of the country. This could indicate a full spectrum of social breakdown, with homelessness and the worst cases of SMI at one extreme. Once again, although this does not prove causality, the disparity of marriage rates in this group as compared to all homeless and all the SMI population adds to the mounting evidence that homelessness in this group is possibly the effect of social estrangement.

A caveat for this research needs to be made in order to address a problem presented in the

study by Folsom et al. Although this study presents compelling evidence that social causes are primarily responsible for the increased risk of homelessness in the SMI population, there was an interesting demographic problem in this particular example. SMI is generally treated as a contiguous population in research summaries on the population; however, researchers in this study broke down the diagnosis of SMI to sub-categories, including diagnosis of major depression, bi-polar disorder, and schizophrenia. When these variables were examined against residential status it was found that in the SMI population that was studied, schizophrenics were a third more likely to be homeless than not, and major-depressive patients were more likely to be housed by roughly the same amount (Folsom et al., 2005). Although this indicates that it may not be accurate to claim that all categories of SMI are equally associated with homelessness, other studies that have compared populations of homeless and domiciled SMI populations have found no difference (Lehman et al., 1995). Further research on the effects of specific diagnosis would be warranted in the search for causality.

It should be noted, that even if it were determined that schizophrenic individuals are more prone to homelessness than the rest of the SMI population, one still could not assume that the actual symptoms of the disorder were the cause; stigmas and self-fulfilling prophecies almost certainly affect these disorders in different ways as large pharmaceutical companies attempt to create a culture of normalcy around anti-depressants, while schizophrenia and anti-psychotics still remain in the realm of the abnormal. This is supported by a study performed by Phelan et al. of public conceptions of mental illness (2000). This study modeled itself after an earlier study conducted in 1950 on conceptions of mental illness in order to determine changes in beliefs

about mental illness. It was found that individuals in 1996 were less likely than those in 1950 to think of psychosis in association with mental illness, and were more tolerant of the mentally ill in general. However, those surveyed in 1996 that *did* associate mental illness with psychosis were also more likely than the group of 1950 to associate this with violent behavior. This fits nicely with the idea that mental illness has become highly stratified to society and needs to be studied as distinct groups in the future. This also lends to credence to the idea that social support plays a significant role in homelessness, as the most heavily stigmatized portion of the SMI population today is also the most prone to homelessness (Folsom et al., 2005; Phelan et al., 2000).

It is my opinion that research clearly points to social dysfunction as a major cause of the increased risk of homelessness for individuals with SMI. Although many of these people would be likely to benefit from economic and housing resources such as SSI, or SRO programs, this is a generalized treatment that may neglect a very important variable in this group.

Summary In the identification of this problem, it was found that there is a rate of SMI in the homeless that is three times larger than in the general population. Additionally, it was found that this portion of the homeless population has longer homeless spells, more homeless spells in a given lifetime, and suffers from a lower quality of life than the rest. It was determined that despite the common suspicion of psychiatric symptoms causing homelessness, this does not appear to be a strong or consistent factor. Instead measures of social functions, such as the size of social networks or history of marriage, reveals that the homeless SMI population suffers from serious social deficiencies.

Program Formation

During the course of my studies in this discourse community, I have discovered two eminent programs that show promise for the prevention of homelessness. The next two subsections of this thesis will discuss the history, results, and various aspects of the Assertive Community Treatment program, and the Critical Time Intervention program. The final subsection will use select components of the two previous programs to craft a new one that I have chosen to call Time-Limited Assertive Social Construction.

Assertive Community Treatment As one of the oldest community living therapy programs, Assertive Community Treatment (ACT) has been extensively researched, tested, and implemented throughout the United States, as well as internationally (Dixon, 2000). ACT was first developed by doctors Mary Ann Test, Arnold Marx, and Leonard Stein in the early 1970's. Dr. Test states that this program was created primarily as response to the “revolving door syndrome”, in which mentally ill patients that had been determined fit for community living were discharged from the hospital, but quickly returned to the system after experiencing a rapid deterioration in mental health and in many cases, homelessness (as cited in Freeman, 2001).

While it may seem strange to utilize a program that was not specifically designed for the prevention of homelessness in this population, I hold that this program actually presents great potential for this purpose due to the specific factors that it addresses, which also may be responsible for homelessness (Stein & Test, 1980). As stated in the section on potential causes, social networks play a large role in determining if one will end up homeless (Ropers, 1988)

ACT, has gone through many different incarnations in its lifetime, and as a result many variations of the program exist. This has prompted a range of studies upon fidelity in the program (McGrew et al., 1994; McHugo et al. 1999). The core set of ideals associated with ACT have been referred to over the years as Training in Community Living, or TCL (Stein & Test, 1980), Program for Assertive Community Treatment, or PACT (Salkever et al., 1999), and ACT (Lehman et al., 1997).

Leonard Marx and his colleagues created a set of six guidelines (Appendix A) for the natal version of the program (Marx et al, 1973). Upon reviewing these guidelines, it is apparent that one of the key components of ACT is teaching a patient to thrive in their particular community. Rather than endow a mentally ill patient with a set of coping skills that were developed in a controlled, and arguably false environment, such as a psychiatric ward in a state run hospital, ACT endeavors to teach community living. This may seem to be very intuitive step, but it took quite some time and effort before this concept was widely accepted. This kind of work directly follows that of George Fairweather, who advocated a similar program for mentally ill veterans who had a difficult time living in the community (1964). However, even his vision was limited to that of the hospital ward. Fairweather's ultimate goal was to move VA patients permanently into the community, but the majority of the “training” for community living was conducted in the hospital ward, albeit with a great deal of autonomy on the part of the patients. ACT, on the other hand, took an enormous step in advocating for the training of their patients within the community, and this has proven to be a powerful component that produces very little additional strain upon the community (Test & Stein, 1980).

The practice of avoiding hospitalization unless it is absolutely necessary for the welfare of the patient is a result of the primary mission of the architects. The continual admittance of patients to an institutional setting can quickly build an unhealthy dependence on others, which is exactly what this program seeks to avoid. In order to achieve this goal, almost all ACT programs have made their staff available to patients 24 hours a day, seven days a week. This is considered by most proponents of the program as a critical component to breaking the system of hospitalization (McGrew et al., 1994), as a difficult psychotic episode on a holiday or in the middle of the night requires attention, regardless of cultural standards for office hours. If mental health professionals are not available to support community contacts during these difficult times, typically the only remaining resource is the emergency room, and admission for mental health problems can quickly restart a cycle of institutionalization (Test, 1998).

The third and fourth guidelines set down by Marx address essentially the same issue -- pathologically dependent relationships. A primary focus of ACT proponents is to teach individuals who have become dependent upon others that they can do things for themselves, and that it is more rewarding as well. However, this may be impossible if family members and professional supports are relieving individuals of daily pressures by doing tasks for them. For example, a particular social worker had great success with patients and laid the foundation for ACT by regularly helping her patients with their laundry or dishes, teaching them over and over if necessary, but never simply performing these tasks for them (Test, 1998). This particular guideline falls into a serious gray area as it may be affected by subjective opinions of what is too much or too little assistance. New programs that adopt ACT regularly have consultants from the

Assertive Community Treatment Association assist them with development of their program (Lehman et al., 1997)

The fifth guideline calls for an extraordinary level of continuity in care, and is one of the most commonly stated. The average individual is capable of retaining employment, paying their bills, maintaining social networks, and making long-term goals, and yet this individual becomes incredibly frustrated when attempting to obtain all of the necessary mental health services for a friend or family member. When individuals with SMI have lost or strained all of their social networks (as is the hallmark of the homeless), it is unrealistic to expect them to be able to consistently navigate a complicated and disparate mental health system. Therefore it is crucial that any program targeting the socially estranged members of the SMI community offer seamless continuity in care.

The sixth and final guideline for Assertive Community Care is the namesake of the modern designation for the program -- assertiveness. This key component requires that social services not only be available 24 hours a day, seven days a week, but also that they aggressively follow-up their patients to determine if further assistance is required. Research has shown that aggressive contact with patients of ACT increases the likelihood of achieving stable housing (Coldwell & Bender, 2007; Lehman et al., 1997), and the more contact that is made with the program, the shorter a homeless spell is likely to be (McBride et al., 1998).

The ACT program has proven itself to be very effective in treating many different problems in the mentally ill population. It served its original purpose very well, greatly reducing the rate of “revolving door” syndrome in their patients (Stein & Test, 1980), as well as increasing

rates of medication compliance (Dixon et al., 1997), and decreasing the severity of psychiatric symptoms (Coldwell & Bender, 2007). However as encouraging these results are, they are secondary to focus of this thesis.

Of great interest to this work is the set of studies which actually observed an effect upon homelessness. One such study performed upon a group of mentally ill homeless found a significant increase in the number of days spent in stable community housing (Lehman et al., 1997). Another determined that the application of ACT to mentally ill homeless individuals caused them to exit homelessness sooner than those who received any of the other usual services (McBride et al., 1998). A meta-analysis of ACT programs found that six randomized, controlled studies demonstrated a 37% average reduction in homelessness in a population with SMI (Coldwell & Bender, 2007).

While ACT explicitly states that they seek to break pathological dependencies, time-limited services are not part of their essential model. In a study on fidelity of 18 ACT programs, it was found that eminent professionals of the program did not regard time-limitations as particularly important. The average score of importance for time-limited services on a scale of 1 to 7 was a paltry 3.7, with a 1 meaning very unimportant and a 7 meaning very important (McGrew et al., 1994). However, ACT was not designed with the prevention of homelessness as the primary goal, and this perhaps is responsible for the different weight of time-limitations between ACT and CTI.

Critical Time Intervention The second program to be reviewed in this thesis is Critical Time Intervention (CTI). This is a much more recently developed program, having been pioneered in a team led by Ezra Susser during a homelessness prevention study in New York from 1991-1993 (Susser et al., 1997). CTI is a voluntary program that was designed for use during the discharge of individuals from a wide range of institutions, including homeless shelters, mental hospitals, prisons, and any others that sustain high-risk populations for homelessness. The purpose of this program is to assist individuals in reaching a sustainable level of residential stability during the "critical time" period after leaving one of the aforementioned institutions (Valencia et al., 1997).

The architects of CTI describe it as possessing two main components (Appendix B) that are crucial to the program (Valencia et al., 1996). The first component seeks to strengthen the connections to long term social contacts in the patient's life in order to decrease their dependency upon social systems and institutions (Susser et al., 1997). The program contact for the subject seeks to engage the rest of the community in a way that is constructive and long-lasting. Rather than simply arranging an appointment with a community mental health provider (CMHP), the program contact will guide the subject to their appointment as many times as is necessarily in order to establish a relationship between the two. Susser et al. states that this sort of tactic makes a CMHP much more likely to follow up on their patient if they do not show for an appointment, or some other complication occurs. One of the primary goals of CTI is to create a sense of responsibility in the community that ensures the individual with SMI is receiving all of the services that they are entitled to, and that a social breakdown does not occur for the patient.

The second component of CTI is to provide emotional support to their patient in the form

of friendship, as well as practical support for dealing with everyday living situations during the critical period of transition (Susser et al. 1997). This component essentially stipulates that the practitioners ease their patients into the community by helping them to locate the services that they require such as CMHPs, inexpensive stores, etc. The architects of this program state that this portion is individually tailored to each patient, as some required only a few follow-up visits, while others needed extensive help for some time.

The actual delivery of these CTI elements is broken up into three general phases, and is described in great length by Herman et al. (2007). The first 3 months of treatment in the 9-month program are known as the “transition” period. This is the time when the patient is moving from a highly controlled institution into the complex world of fragmented social services. The practitioner provides specialized support for their patient in order to help them adjust to their new surroundings as quickly and effectively as possible. If they have trouble with their landlord, their neighbor, or the family member that they're living with, the CTI worker helps them negotiate. If they do not like their support group, the CTI worker helps them find a new one. If a crisis arises in the middle of the night, the CTI worker helps council them through it. The worker spends a great deal of time in face-to-face contact with their patient in order to provide the most effective support. Essentially, the program attempts to be as helpful as possible in making sure the patient does not suffer from a complete social breakdown.

The second phase of CTI covers the 4-6 month period, and is known as the “try-out” phase. The worker attempts to test some of the patient’s problem-solving skills by withdrawing their support, making fewer visits and ceasing to negotiate for the patient as aggressively. If the

patient responds to this well, the CTI worker continues to decrease involvement in their daily activities, although they monitor them closely. If the patient responds poorly to this and the worker deems it necessary, they may renew some of the first phase support. However, the goal is to force the patient to manage their own lives and negotiate with other effectively by the end of the try-out phase, without overwhelming them so much as to send them back into an institution.

The third phase, referred to as “transfer-of-care”, involves the complete termination of services by the CTI program. Ideally, the worker has gradually reduced their role in the patient’s life while helping them maintain a steady living situation. By the time the program is halted, the patient does not view the end of their contact with a CTI worker as a traumatic loss. It is the final goal of the worker to create a firm safety net for the patient in the form of involved and dedicated CMHPs, and to embed long term goals for employment, education, family involvement, and so forth.

Ezra Susser’s New York study found that the CTI group experienced an average of 30 homeless nights, compared to the usual services only (USO) group which averaged 91 homeless nights over the course of the 18-month study. Keeping in mind that the lasting effects of CTI (i.e. reduced risk of homelessness after withdrawal of services) are the goal of this program, it is very impressive that the original study found not only that CTI patients retained housing much more effectively throughout the study, but that there was only a slight increase in homeless nights in this group after the complete withdrawal of CTI services (Susser et al., 1997).

A powerful motivator for the adoption of a CTI program is the ease with which it can be implemented into a system. Because it does not attempt to alter the existing system to suit a

particularly difficult population, it does not need a great deal of time or resources to become effective. Instead, the intervention relies upon highly-functioning professionals to gradually introduce a patient to the complex network of community services. Additionally, because this program does not call for more therapy or hospital time, there is not a need to hire a number of the most expensive staff in mental health services such as psychiatrists. Instead, this supplemental service relies primarily upon individuals who have already worked with the population and have enough "street smarts" to help their patient navigate the local system. This could include any number of individuals that typically work with the homeless, such as soup-kitchen volunteers, homeless advocates, and even shelter staff.

The economic motivations for the implementation of CTI have been investigated at some length. One such study analyzed the original New York study group of Susser et al. (Jones et al., 2003). The experimental design divided the study population into two groups. These were the CTI group that would receive CTI treatment for 9 months followed by 9 months of usual services, and the USO group that received usual services for 18 months. The economic review of the study estimated the costs incurred by each group for all of the social services they utilized, including mental health costs, SSI, housing subsidies, jail-time, and food stamps. It was found that in the first 9 months of the study that the CTI group cost $457 more per non-homeless night than the USO group (this figure was determined by dividing the average cost of an individual by the average number of non-homeless nights). However, the purpose of the program is to provide lasting effects on homeless prevention after the completion of the CTI services. This was reflected in the second 9 months of the study when the additional cost of each non-homeless for

the CTI group fell to $152. Additionally, Jones et al. points out that they were unable to assign an actual cost for each homeless day, even though there is definitely some cost to society. Therefore, the cost of each non-homeless night for the CTI group is likely to be even less.

Time-Limited Assertive Social Construction At this time I will lay out the framework for my proposed program. It should be noted that a project of this length, written by an author with limited training, is not meant to be an in-depth technical manual. Instead it is meant to be an exploratory work that relies upon the precedent of successful research, building a program out of established components to serve a specific population earlier in the course of their mental health difficulties. This program will differ from those in existence by serving an entirely new population. Rather than waiting for homelessness to occur in order to identify candidates for a prevention program, it will seek out those in the SMI population who are at risk for homelessness before they lose their residential stability. Proven methods of community treatment will be used to stem this problem earlier in the chain of progression.

The result of this synthesis, which I have named Time-Limited Assertive Social Construction (TLASC), attempts to implement the most important elements of ACT and CTI into a single effective program to serve a population and a purpose not previously targeted by the scholars in this community. A large body of evidence indicates that homelessness is primarily a symptom of economic factors; lack of jobs, affordable housing, and insufficient social systems all contribute the problem which millions of Americans have to face every year. However, research that indicates additional risk factors for the SMI population calls for supplemental

solutions besides increasing low-income housing and SSI. TLASC is designed to assist the portion of the population that suffers not only from economic woes, but also from the social breakdown that so frequently coincides with mental illness and seems to be associated with homelessness.

The TLASC program is composed of four guiding principles (Appendix C) which are derived from those of the ACT and CTI programs. The most essential component of TLASC is its advocates. These practitioners will function in a very similar capacity to those from the two model programs discussed above; escorting patients to appointments, introducing them to service providers, assisting them with basic skills that need to be developed, and negotiating on their behalf whenever they are unable to come to an accord with family or community contacts. They will play a crucial role in reinforcing existing social contacts, and encourage the creation of new social contacts wherever this is possible. This could be performed by suggesting that a patient to join an appropriate group in the community, such as a church choir if they are religious, alcoholics anonymous if they are struggling with chemical dependencies or even a discussion group composed of other TLASC patients.

TLASC will not provide any mental health services or counseling, but rather will attempt to make the existing services more effective by ensuring that their respective patients are actually utilizing them to the fullest. Advocates will extend the reach of mental health workers who currently practice from a fixed location, and cannot afford to spend their limited time driving a patient to his next appointment. The extent of the services that are offered to each patient will be dependent upon the actual phase of program in which an individual exists. The phases of TLASC

are discussed in detail below.

The time-limited aspect of TLASC is directly borrowed from CTI as a means of making the program have long-lasting effect after the cessation of services. CTI seeks the prevention of homelessness, and uses time-limited services as a means of breaking dependency upon the program. This presumably serves as a method of cost-control for a population that is often characterized as an excessive burden to society. It is my opinion that the CTI emphasis on time-limited services is most appropriate considering the goal of the TLASC program, and therefore the later will adopt the strategy of the former.

In order to hold true to research precedent, TLASC will break up its service tiers into three phases. The entire program will last a total of 9 months, with each phase intended to take approximately 3 months to complete. Graduation of a patient from one phase to another will result in a gradual reduction of services in order to prevent undue stress to the patient; a meeting of advocates may determine that a patient is ready to move to the next phase, but primary advocate should take several weeks to implement the changes slowly. Ideally, the patient would be unaware of the actual change of phases, instead experiencing the entire program as one contiguous and slowly tapering program.

Obviously with so much depending upon the abilities of a single advocate, it is incredibly important that they be well qualified for their duties. The original study on CTI was able to achieve significant results without requiring their advocates to hold a professional degree (Susser et al., 1997). This is a practice that has enormous implications for cost-management, and there is a great deal of evidence to support the use of paraprofessionals in lieu of professionals. Joseph

Durlak found that paraprofessionals were at least as effective or more effective than professionals in all but 2 of 42 reviewed studies (1979). Other scholars countered that only 5 of these 42 studies showed sufficient evidence of paraprofessional's efficacy, but Hattie et al. later countered that while Durlak's evidence may not be as strong as he initially claimed, there was still significant evidence of paraprofessionals being at least as effective as professionals (1984). Even later reviews of the rich body of research that surrounds this topic are also in favor of Durlak's conclusion that paraprofessionals are at least as effective as professionals, though certain factors have a strong correlation to each groups effectiveness (Christensen & Jacobsen, 1994).

In accordance with the conclusions of Durlak, and the experience of Susser, the TLASC program will be supervised by a psychiatrist or other mental health professional of comparable training, but the advocates themselves would only be required to have past experience working with the SMI population, and be savvy enough to perform all of their duties in the community on their own. Essentially the advocate would be the opposite of their patients – a socially functional individual who is able to effectively and consistently utilize the resources of the community. Meetings between the TLASC staff and the supervising mental health professional would occur on a daily basis, as recommended by ACT practitioners, in order to share experiences, consult each other for ideas, and receive corrections from their supervisor (McGrew et al., 1994)

It is of the utmost importance that the reader understands the scope of the population that will served by TLASC. This program seeks to prevent homelessness in the SMI population, whereas CTI effectively seeks to restore residential stability to those who have already become

homeless or lost their regular living arrangements due to incarceration or hospitalization. In order to achieve this, the services provided by this program will be offered to all adult patients recommended by CMHPs. It goes without saying that this would require an incredible amount of cooperation from both CMHPs and patients; it would be necessary to convince providers of the efficacy of this program before they could ethically recommend the program to their patient. This evidence would almost certainly have to begin in the form of a single-provider study.

A set of criteria would need to be established in order to identify the patients that are at the most risk of social breakdown and homelessness. Possible criteria could include a low rating on the Social Network Interview (Bates & Toro, 1999), low or decreasing socioeconomic status, and the presence of other indicators for hospitalization. Community mental health providers (CMHP) would likely be the best resource for the development of specific criteria, as they would ultimately be the ones to recommend their patients for TLASC program. Once these criteria were established, the control and experimental groups could be established by randomly dividing in half the consenting patients who fit the criteria. The experimental group would receive TLASC while the control group would receive usual services only.

It is noteworthy that other than the initial costs of establishing criteria for admission to the TLASC program, there would be essentially no cost to CMHPs. The employees responsible for contact with CMHPs could provide a list of these criteria, urging practitioners to forward the information of any candidates for the program, at which point the TLASC program would bear all of the remaining costs. However, in order to ensure that this program is not financially infeasible from its inception, at this time it does not seek to treat individuals that have not been

initiated into the local mental health systems. Although there are certainly people who have mental illness and do not see a mental health provider, this author does not see a simple solution for locating these people in a manner that is timely or cost-effective. It is possible that a separate program which is developed with the specific purpose of identifying this underserved population could be used in conjunction with TLASC to a great effect.

In order to determine an appropriate caseload for each TLASC advocate, my program will modify those used by CTI programs (Herman et al., 2007). Workers in the cited study had a total of 12 patients overall, distributed evenly among the three phases (four in the first, four in the second, and four in the third). However, a fidelity study of ACT programs found that a caseload of less than ten patients was considered very important to practitioners (McGrew et al., 1994). In light of this, I believe it would be appropriate for each advocate to have a caseload of nine patients, with three in each phase of the program at any one time. It is possible that a low case-load will incur much too high a cost in order to maintain the feasibility of this program, but that would depend entirely upon too many variables to discuss at this time. Although the results may not be as impressive, I believe that an advocate could manage a case-load of 12 patients and still be effective if it were deemed necessary to lower the cost of the program. Higher case-loads may still be effective, but there is currently no research to explore this.

The three phases of TLASC are modeled after the CTI program, and include Outreach, Construction, and Reduction. Much like CTI's Transition phase, Outreach seeks to build up a relationship of trust with the patient, assisting them through their most difficult times and assertively engaging the community to interact with the patient. The Construction phase seeks to

reduce the role of the advocate, increase the presence of the community in the patient's life, and vice versa. Finally, the Reduction phase attempts to completely eliminate any dependency upon the advocate in order to determine if the patient is capable of functioning with the help of their newly established social networks.

Outreach. This phase will take place after advocates have received a recommendation from a CMHP, met with the patient, and accepted them into the program. As in the first phase of CTI, the primary focus of outreach is to stabilize the patient's social networks and to build a great deal of trust between patient and worker. The advocate will make regular house calls, making face-to-face contact with the patient at least 3 times a week throughout the first phase. Additionally, a program contact would be available to counsel the patient twenty-four hours a day, seven days a week, either on the phone or in person if necessary, as this is one of the components identified by ACT practitioners as crucial to their own program (McGrew et al., 1994). Obviously it would be impossible for the patient's specific advocate to be available at all times, but this individual would need to make themselves available as much as possible.

During their regular visits, advocates would help their patient with whatever tasks needed to be taken care of. This could include things such as paying bills, applying for jobs, or scheduling appointments, and managing medications. The advocate would also do whatever they could to encourage their patient to engage in positive social behaviors, such as writing letters or emails to friends, engaging their neighbors in conversation, etc. These activities are guided by principles III and IV of the ACT program, which emphasize breaking pathologically dependent relationships and reinforcing the positive aspects of social living (Marx et al., 1973). If a worker

has difficulty in making the patient engage in social activities and has to make a choice between being pushy or gaining their patient's trust, then the later would be the preferred course of action during the this phase. This is in line with principle I the CTI program, which stresses emotional support for the patient (Susser et al., 1997).

The worker also ensures that patients are actually making their appointments with CMHPs. This is very important activity to ACT and CTI, as it is the primary method of increasing continuity of care. In the first few weeks of TLASC, the advocate would actually show up at the patient's residence and escort them to their appointment. This could include driving the patient to their appointment, following them to the appointment if they drive, or riding public transportation with them if it is pertinent. It would be important that the worker helps to reinforce the method of transportation that the patient will use in the future in order to reduce stress during the later phases of the program when services will not be as widely available. As the patient becomes more comfortable with their travel arrangements, the advocate may then elect to meet the patient at their destination.

Advocating for the patient with mental health providers would be a crucial activity. Ideally, the TLASC program will be able to engage the patient and their CMHP in a way that makes both responsible to each other. As stated by Herman et al., some providers may be so distressed by a potential patient’s behavior that they are relieved when the patient doesn't come back (2007). It would be the advocate's goal to build a relationship between patient and provider that would make the patient feel responsible for showing up to their appointments, and the provider responsible for following up with the patient if they don't.

Construction. In this phase, the time-limited component of CTI will be utilized in order to foster independence in the patient. The construction phase of the program features a reduction in the actual amount of time that an advocate spends with a patient, and an increase in the amount of responsibility upon the patient. The advocate will still make house calls, but should meet with their patient in person roughly once a week unless otherwise requested by the patient. The advocate should still contact their patient frequently, but a transition to phone-calls and emails should have gradually taken place in the first weeks of the construction phase. Another significant change in this phase is the availability of TLASC staff. Although the patient may still talk on the phone with the TLASC staff 24 hours a day, they may no longer request a house call at any time. House calls by staff will be limited to regular business hours of 9-5, Monday through Friday. Obvious exceptions include emergencies in which the patient is a danger to themselves or others, and in such cases an advocate will be dispatched along with whatever other emergency services are necessary.

The limited face-to-face contact with the patient will be used to role play situations that the patient faced the previous week, attempting to recreate challenging situations that they faced and offer an opportunity to come up with a solution in a safe environment. In direct imitation of CTI, if the patient is having a great deal of trouble with any particular person, such as neighbor who complains about the outward appearance of the patient or a bus driver that dislikes their behavior, the worker may elect to negotiate with this person directly (Herman et al., 2007). However, this should be a rare occurrence and take place in the presence of the patient in order to encourage active dialogue between the two parties with minimal input from the advocate.

A greater effort should be made by the advocate to encourage and reinforce social activities. If their patient is attending a group meeting on a regular basis, the worker should try to hold their weekly meeting at the same location as the group. In this way, the patient would be held accountable for both their consultation and their chosen social activity.

The advocate should attempt to meet several times with the individuals that the patient designates as their most important community contacts. These meetings should serve as a time for the advocate to brief these individuals on strategies for fostering the patient's social skills, as well as preventing pathological dependence from developing in these relationships in accordance with principle III of ACT (Marx et al., 1973). It may be useful for a class on these subjects to be offered to community members, but research would need to be conducted to determine if such a venture would be worthwhile.

Regular phone calls should be used to track the patient's progress with appointments and deliver advice on issues with transportation, housing, and employment. If the patient seems to be having specific problems, such as paying for rent, the worker should encourage the patient to seek out the appropriate assistance and provide any information that they have about these services. However, the worker should no longer attempt to schedule appointments or advocate for their patient unless it is absolutely necessary.

Reduction. The reduction phase features the most limited amount of services throughout the program. TLASC staff are no longer on call for the patient 24 hours a day, but will still provide information during regular business hours. Additionally, the advocate will no longer make regular house calls to their patient, instead relying entirely upon phone calls once or twice

a week to monitor their patient's progress. The worker may still make a visit to their patient if it is requested and a need is justified, but this should be avoided as much as possible.

Community contacts and CMHPs that are treating the patient will also be contacted on occasion to determine if the patient appears to be doing well by community standards. If community members feel that they are still ill-equipped to help the patient then the advocate may choose to counsel them further.

At this point the advocate's efforts towards continuity should have already been quite successful. However, they should still attempt to prompt some of the lessons that they have been teaching their patients by asking them questions like "how do you feel about your appointments with your doctor?", in order to prompt the patient to seek further professional assistance if it is necessary.

In imitation of CTI studies, as well as others that have sought community based solutions to social problems, the program would end with a celebration. In order to reaffirm the lessons taught throughout the program and provide one final test of their patient's abilities, a party would be thrown for all of the patients in a cohort, as well as the advocates. It would be of the utmost important that this event not seem to patronizing to the patients, but rather an earnest celebration of successfully completing the program. This would also be a very useful opportunity to gather input from the patients in order to improve the program. A standardized self-report form that asked the patients to rate the different components of the program, used in conjunction with an open forum for patients to express their feelings and experiences, could be used to shape the successive generations of the TLASC program.

Conclusion

Though there is already a great deal of direct evidence that points to social dysfunction as a major cause of homelessness in the SMI population, the effectiveness of programs such as ACT and CTI that directly target social dysfunction add even more weight to this argument. Both of the aforementioned programs utilize community based learning, individualized interaction, and generally attempt to restore a healthy social functioning to their patients. Because of the effectiveness of these interventions in decreasing the number of days spent in homelessness, it seems prudent to expand these concepts to a larger population in order to determine if greater effects can be achieved in a much wider audience through true prevention of homelessness.

Effective implementation of TLASC will not completely eliminate the SMI population from the ranks of the homeless. Indeed, even if a perfect program were designed to address social dysfunction in SMI populations, there would still be a portion that suffered from economic woes. If SMI were completely mitigated as a factor in homelessness, then one would still expect that at least 6% of the homeless population would be affected by SMI, as that is the prevalence in the general population. Though scholars have argued that the similarity in rates of SMI between the homeless and the poor demand economic programs, I believe that this is even more convincing evidence of the need for social modifications. One may expect that if the over representation of SMI in the homeless were eliminated through social construction, then the over representation of SMI in the lowest SES may disappear as well.

A major vulnerability of the TLASC program will be during implementation, as the design relies upon the cooperation of CMHPs for screening of candidates. Furthermore, the

specific use of mental health providers will exclude the portion of the SMI population that does not seek treatment for their disease. However, it seems that alternative methods would be prohibitively expensive, eroding the strong economic incentives for the implementation of this program.

The wide-scale use of a program like TLASC would have serious implications in the domain of homelessness prevention in SMI populations. It could be said of existing programs that they do not actually prevent homelessness – instead they restore residential stability to those individuals who have succumbed to various risk factors, and this does little for those teetering on the edge stability for the first time. TLASC seeks to engage the SMI population before they become homeless in the attempt to prevent the multitude of problems that come along with homelessness.

Although this thesis attempts to illuminate the available research and bodies of evidence as much as possible, it is impossible to encompass the copious amounts of work that have been conducted on this subject. Further reading for specialized services for the mentally ill include that of Sosin and Grossman who assert that prior studies have examined homelessness in isolation of many contributing factors (1991). To better understand the long and rich history of ACT, one might review the series of articles that examined the effectiveness, economic cost, and social cost of a precursor to the ACT program (Stein & Test, 1980; Weisbrod et al., 1980; Test & Stein, 1980). Additional information on the CTI program will soon be available as a multitude of recent studies conclude and publish their results (Herman et al., 2007).

Further research that would be of great benefit would focus on identifying individuals

with SMI who are not already part of mental health networks. If an effective method were to be discovered for this purpose then TLASC would become an even more powerful program. Additionally, research on the TLASC program itself will need to be conducted in order to determine the effect of each variable when applied to this population.

Reference

American Psychological Association. (2000). *Diagnostic and statistical manual of mental disorders* (Revised 4th ed.). Washington, DC.

Bassuk, E.L., Rubin, L., Lauriat, A. (1984) Is homelessness a mental health problem? *American Journal of Psychiatry*, *141*, 1546-1550.

Bates, D.S., Toro, P.A. (1999). Developing measures to assess social support among homeless and poor people. *Journal of Community Psychology*, *27*(2), 137-156.

Beicher, J.R. (1989). On becoming homeless: A study of chronically mentally ill persons. *Journal of Community Psychology, 17*, 173-185.

Calsyn, R.J., Winter, J.P. (2002). Social support, psychiatric symptoms, and housing: A causal analysis. *Journal of Community Psychology*, *30*(3), 247-259.

Caton, C.L., Wyatt, R.J., Grunberg, J., Felix, A. (1990). An evaluation of a mental health program for homeless men. *American Journal of Psychiatry*, *147*, 286-289.

Christensen, A., Jacobsen, N. (1994). Who (or what) can do psychotherapy: The status and challenge of nonprofessional therapies. *Psychological Science, 5*(1), 8-14.

Cohen, C.I., Thompson, K.S. (1992) Homeless mentally ill or mentally ill homeless? *American Journal of Psychiatry*, *149*, 816–823.

Coldwell, C.M., Bender, W.S. (2007). The effectiveness of Assertive Community Treatment for homeless populations with Severe Mental Illness: a meta-analysis. *American Journal of Psychiatry, 164*, 393-399.

Cuomo, A., Halala, D.S. (August 1998). *Practical lessons: The 1994 national symposium on homelessness research.* Retrieved from http://aspe.hhs.gov/pic/reports/aspe/6817.pdf#page=75, May 16th, 2010.

Dixon, L.B., Weiden, P., Torres, M., Lehman, A.F. (1997). Assertive community treatment and medication compliance in the homeless mentally ill. *American Journal of Psychiatry, 154*, 1302-1304.

Dixon, L., (2000), Assertive Community Treatment: Twenty-five years of gold. *Psychiatric Services, 51*(6), 759-765.

Draine, J., Salzer, M., Culhane, D., Hadley, T. (2002). Role of social disadvantages in crime, joblessness, and homelessness among persons with serious mental illness. *Psychiatric Services*, *53*(5), 565-573.

Draine, J., Herman, D. (2007). Critical Time Intervention for reentry from prison for persons with mental illness. *Psychiatric Services, 58*(12), 1577-1581.

Durlak, J.A. (1979). Comparative effectiveness of paraprofessional and professional helpers. *Psychological Bulletin, 86*(1), 80-92.

Fairweather, G. (1964). *Social psychology in treating mental illness.* New York, NY: John Wiley & Sons, Inc.

Fischer, P.J. (1989). Estimating the prevalence of alcohol, drug, and mental health problems in the contemporary homeless population: a review of the literature. *Contemporary Drug Problems*, *16*, 333.

Fischer, P.J., Breakey, W.R. (1991). The epidemiology of alcohol, drug, and mental disorders among homeless persons. *American Psychologist, 4*(11), 1115-1128

Folsom, D.P., Hawthorne, W., Lindamer, L., Gilmer, T., Bailey, A., Golshan,....Jeste, D.V. (2005). Prevalence and risk factors for homelessness and utilization of mental health services among 10,340 patients with serious mental illness in a large public mental health system. *American Journal of Psychiatry*, *162*, 370-376.

Freeman, J. (November 2001). *ACT History and Origins.* Retrieved from http://www.actassociation.org/origins/ ; May 14th, 2010.

Hattie, J.A., Sharley, C.F., Rogers, H.J. (1984). Comparative effectives of professional and paraprofessional helpers. *Psychological Bulletin, 95*(3), 534-541.

Herman, D., Conover, S., Felix, A., Nakagawa, A., Mills, D. (2007). Critical Time Intervention: An empirically supported model for preventing homelessness in high risk groups. *Journal of Primary Prevention*, *28*, 295-312.

Jones, K., Colson, P.W., Holter, M.C., Lin, S. Valencia, E., Susser, E., et. al (2003). Cost effectiveness of Critical Time Intervention to reduce homelessness among persons with mental illness. *Psychiatric Services*, *54*(6), 884-890.

Kuno, E., Rothbard, A.B., Averyt, J., Culhane, D. (2000). Homelessness among persons with Serious Mental Illness in an enhanced community-based health system. *Psychiatric Services*, *51*(8), 1012-1016.

Lehman, A.F., Cordray, D.S. (1993). Prevalence of alcohol, drug, and mental disorders among the homeless: one more time. *Contemporary Drug Problems*, *20*(3), 355-386.

Lehman, A.F., Kernan, E., Deforge, B.R., Dixon, L. (1995). Effects of homelessness on the quality of life of persons with severe mental illness. *Psychiatric Services*, *46*(9), p. 922-926.

Lehman, A.F., Dixon, L.B., Kernan, E., DeForge, B.R., Postrado, L.T. (1997). A randomized trial of Assertive Community Treatment for homeless persons with severe mental illness. *Archives of General Psychiatry*, *54*, 1038-1043.

Lipton, F., Sabatini, A., Katz, S. (1983). Down and out in the city: The homeless mentally ill. *Hosptital and Community Psychiatry, 34*(9), 817-821.

Marx, A.J., Test, M.A., Stein, L.I., (1973), Extrohospital Management of Severe Mental Illness, Feasibility and Effects of Social Functioning, Archives of General Psychiatry, *29*, 505-511.

McBride, T.D., Calsyn, R.J., Morse, G.A., Klinkenberg, W.D., Allen, G.A. (1998). Duration of homeless spells among severely mentally ill individuals: A survival analysis. *Journal of Community Psychology, 26*(5), 473-490.

McGrew, J.H., Bond. G.R., Dietzen, L., Salyers, M. (1994). Measuring the fidelity of implementation of a mental health program model. *Journal of Consulting and Clinical Psychology*, *62*(4), 670-678.

McHugo, G.J., Drake, R.E., Teague, G.B., Xie, H. (1999). Fidelity to Assertive Community Treatment and client outcomes in the New Hampshire dual disorders study. *Psychiatric Services*, *50*(6), 818-824.

Mojtabai, R. (2005). Perceived reasons for loss of housing and continued homelessness among homeless persons with mental illness. *Psychiatric Services*, *56*(2), 172-178.

National Coalition for the Homeless (2009). *Mental illness and homelessness*. Retrieved from http://www.nationalhomeless.org/factsheets/Mental_Illness.pdf; April 13th, 2010.

Phelan, C., Link, B.G., Stueve, A., Pescosolido, B.A. (2000). Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared? *Journal of Health and Social Behavior, 41*(2), 188-207.

Piliavin, I., Westerfelt, H., Elliott, E. (1989). Estimating mental illness among the homeless: The effects of choice-based sampling. *Social Problems*, *35*(5), 525-531.

Ropers, R. (1988). *The invisible homeless: a new urban ecology.* New York, NY: Human Sciences Press.

Roth, D., Bean, G.J. (1986). New perspectives on homelessness: Findings from a statewide epidemiological study. *Hospital and Community Psychiatry, 37,* 712-719.

Salkever, D., Domino, M.E., Burns, B.J., Santos, A.B., Deci, P.A., Dias, J....Paolone, J. (1999). Assertive Community Treatment for people with severe mental illness: The effect on hospital use and costs. *Health Services Research*, *32*(2), 577-601.

Sosin, M.R., Grossman, S. (1991). The mental health system and the etiology of homelessness: A comparison study. *Journal of Community Psychology*, *19*, 337-350.

Stein, LI., Test, MA. (1980) Alternative to mental hospital treatment. I. Conceptual model, treatment program, and clinical evaluation. *Archives of General Psychiatry*, *37*(4), 392-397.

Sullivan, G., Burna, A., Koegel, P., Hollenberg, J. (2000). Quality of life of homeless persons with mental illness: Results from the course of homelessness study. *Psychiatric Services*, *51*(9), 1135-1141.

Susser, E., Valencia, E., Conover, S., Felix, A., Tsai, W., Wyatt, R.J. (1997). Preventing recurrent homelessness among mentally ill men: A "critical time" intervention after discharge from a shelter. *American Journal of Public Health*, *87*(2), 256-262.

Task Force on Psychology and Public Policy (1986). Psychology and public policy. *American Psychologist*, *41*(8), 914-921.

Test, M.A., Stein, L.I. (1980) Alternative to mental hospital treatment. III. Social cost. *Archives of General Psychiatry*, *37*(4), 409-412.

Tompsett, C.J., Toro, P.A., Guzicki, M., Manrique, M., Zatakia, J. (2006). Homelessness in the United States: Assessing changes in prevalence and public opinion, 1993-2001. *American Journal of Community Psychology*, *37*, 47-61.

Trumbetta, S.L., Mueser, K.T., Quimby, E., Bebout, R., Teague, G.B. (1999). Social networks and clinical outcomes of dually diagnosed homeless persons. *Behavior Therapy*, *30*, 407-430.

Valencia, E., Susser, E., McQuiston, H. (1996). Critical time points in the clinical care of homeless mentally ill individuals. In J. Vaccaro, & G. Clark (Eds.), *Practicing psychiatry in the community: A manual* (pp. 259–276). Washington, DC: American Psychiatric Press.

Valencia, E., Susser, E., Torres, J., Felix, A., Conover, S. (1997). Critical time intervention for homeless mentally ill individuals in transition from shelter to community living. In W. Breakey, & J. Thompson (Eds.), *Mentally ill and homeless: Special programs for special needs* (pp. 75–94). Newark, NJ: Gordon and Breach Science Publishers.

Weisbrod, B.A., Test, M.A., Stein, L.I. (1980) Alternative to mental hospital treatment. II. Economic benefit-cost analysis. *Archives of General Psychiatry*, *37*(4), 400-405.

Appendix A

Components of Assertive Community Treatment (ACT)

I. Treatment concentrated primarily on patients' acquiring coping skills necessary to live in the community and enjoy a reasonable quality of life – the acquisition of these skills would take place in the community.

II. A virtual abstention from hospitalizing any patients being managed in the community.

III. Work with families and significant others primarily directed towards the goal of breaking pathologically dependent relationships.

IV. Staff relating to patients as responsible individuals and taking maximal efforts to expose them to the reinforcements and contingencies of living in society.

V. A close working relationship with a very wide variety of community facilities – from agencies to individuals – in order to ensure consistency and continuity of the approach.

VI. A markedly assertive orientation in order to minimize the possibility of patients dropping out of treatment.

Appendix B

Components of Critical Time Intervention (CTI)

I. Strengthen the individual's long-term ties to services, family, and friends.

II. Provide emotional and practical support during the critical time of transition.

Appendix C

Components of Time-Limited Assertive Social Construction (TLASC)

I. Treatment focuses on reinforcing a patient's ability to live a productive and healthy life through regular, constructive social contact.

II. Advocates engage and educate community contacts such as friends and family to help break a patient's pathological dependencies.

III. Advocates expertise is utilized on an individual basis in order to provide greater continuity of care by community mental health providers.

IV. Tapered time-limited services allow assertive treatment to be utilized with a greatly decreased risk of creating dependency upon the program.