11.2 Homelessness Exercise

Chronic Homelessness and Mental Illness

The Context
This document is part of one chapter of a 136-page report of research about ways to end chronic homelessness associated with mental illness and substance abuse. It will be read by policy makers who have the power to fund programs and pass legislation.

Instructions
Goals of editing: This assignment asks for basic copyediting: making the document correct and consistent. In addition, you will edit for grammar and punctuation, spelling, and use of numbers. You will create a **style sheet.**

Method of editing

You can use these specifications for structural markup:

CN (chapter number)	Arial 14-pt bold ital, left-justified, caps and lower case; 3 pts after;
CT (chapter title)	Arial 20 pt bold, left justified, caps and lowercase, 12 pts before, 12 pts after
Ab (abstract)	Times 12 ital; block indent ¼ inch;
H1 (heading 1)	Arial 14-pt bold, left-justified, caps and lower case; 12 pts before, 3 pts after;
H2 (heading 2)	Times 12 bold, 4 pts before, 2 pts after
P1 (paragraph after a heading, title, or abstract)	Times 12, left justified; no indent;
P2 (follows another paragraph)	Times 12, left justified; indent ¼ inch

Set your margins as follows: 1" top, bottom, and right; 1.25" left.

Include queries to the author if you have questions about content.

Attach a style sheet. Prepare the style sheet on the computer and arrange the entries for terms alphabetically, with separate categories for numbers and punctuation styles. This document is just part of a longer document. Include on the style sheet items for which an editor might have to make a choice even if the item appears only once in this document. Follow the style preferences recommended by *The Chicago Manual.*

Chapter 1

Understand the Changing Context of Care and the Nations Response

> Homelessness has become an enduring presence in American society. Despite two decades of Federal support, statewide planning, and local initiatives, an estimated 637,000 adults in the United States are homeless in a given week, with 2.1 million adults experiencing homelessness over the course of a year (Burt et al., 2001).

Most studies show that the majority of people who become homeless are without a place to live for only a short period of time. They usually become homeless as a result of an unexpected event such as an eviction, natural disaster or house fire, and tend to have more social and economic resources to draw on than those who remain homeless for longer periods of time.

A much smaller group of homeless people either is episodically homeless (i.e., have many episodes of homelessness but each for short periods of time) or are chronically homeless (i.e. have few episodes of homelessness but each for long periods of time.) One study of shelter users in two large cities found that 80 percent were temporarily homeless, 10 percent were episodically homeless, and 10% were chronically homeless (Kuhn & Culhane, 1998).

The estimated 200,000 people who experience chronic homelessness tend to have disabling health and behavioral health problems. Recent estimates suggest that at least 40 percent have substance use disorders, 25 percent have some form of physical disability or disabling health condition, and 20 percent have serious mental illnesses (Culhane, 2001). Often individuals have more than one of these conditions. These factors contribute not only to a persons risk for becoming homeless but also to the difficulty he or she experiences in overcoming it. People, who experience chronic homelessness, also tend to be slightly older than those who experience shorter homeless episodes, are non-white, and male (Culhane and Kuhn, 1998). Families and youth experience chronic homelessness, as well.

THE CHANGING CONTEXT OF CARE

Serious Mental Illnesses

Gone are the days when people with serious mental illnesses spent most of their lives in large, impersonal state institutions. The locus of care for people with serious mental illnesses have shifted over the past 30 years from the state hospital to the community. The number of patients in state psychiatric hospitals dropped from 560,000 people in 1955 to 77,000 people in 1996 (Bachrach 1996).

Much of the decrease in the state hospital census can be attributed to deinstitutionalization which sought, in part, to address well-publicized abuses in state hospitals by shifting treatment to the least restrictive setting for people with serious mental illnesses. Deinstitutionalization was abetted by the introduction in the 1950's of antipsychotic medication and by the creation of the Medicaid and Supplemental Security Income (SSI) programs in the 1960s that provided financial incentives for community care.

However, the realities faced by people with serious mental illnesses in their communities were in stark contrast to the promise of deinstitutionalization. The Community Mental Health Centers (CMHC) Act of 1963 was designed to address the needs of people with mental illnesses in their communities but the vast array of needed services and supports never materialized.

In particular, fewer CMHCs than anticipated were created, and those established offered primarily clinic-based services that frequently were inaccessible or inappropriate for individuals with the most serious disorders. As a result, many individuals leaving institutions never connected with community based mental health services. Others cycled in and out of jails and prisons. Without assistance, people with serious mental illnesses were among the first to be displaced when urban neighborhoods and single-room-occupancy hotels were gentrified in the 1980s.

By the late 1970s, the Community Support Program (CSP), now administered by SAMHSA's Center for Mental Health Services (CMHS), was adopted as the framework for developing a comprehensive range of services that would allow people with serious mental illnesses to live successfully outside of institutions. Some of the elements of the CSP approach included: outreach, income and medical assistance benefits, 24-hour crisis assistance, psychosocial rehabilitation, employment services, long-term supportive services, medical and mental health treatment, family support, residential services, case management, rights protection and advocacy. Today, these elemants remain as the cornerstone of comprehensive, community-based systems of care for people with serious mental illnesses.

Some communities have programs specifically designed to serve people with serious, mental illnesses who are homeless. These programs include emergency shelters, outreach programs, drop-in centers, transitional housing, and health care. Outreach programs have been effective in reaching people with serious mental illnesses who are homeless, especially those who are unable or unwilling to accept help from more traditional office-based providers. In many cases, these efforts are literally saving people's lives.

While success stories exist, the numbers of people in need far exceed the capacity of programs that provide the intensive outreach and case management services required. Many people with serious mental illnesses receive fragmented and uncoordinated treatment, housing, and support services, if they receive them at all. They may cycle in and out of hospitals, jails, shelters, and life on the streets at enormous cost to both themselves and their communities.

Substance Use Disorders

In the not so distant past, "public inebriates typically were sent to the drunk tanks of local jails to dry out. In 1956, the American Medical Association declared alcoholism a disease, lending support for medical treatment instead of incarceration. The 1971 Uniform Alcoholism and Intoxication Treatment Act, also known as the Hughes Act, officially decriminalized public drunkenness and mandated a medical treatment approach.

Instead of being jailed, homeless people who were alcoholics were sent to publicly funded detoxification programs where they could receive some form of treatment. (Stark, 1987) However, studies of detoxification programs for indigent people reveal that few individuals leave with referrals for treatment and the majority of those who are given referrals do not use them. These results led the researchers to conclude that the [Hughes] Act had replaced the revolving jail door with a "padded revolving door" (Sadd and Young, 1987).

Though medical treatment is still a mainstay for individuals with substance use disorders; this approach has it's drawbacks for people who are homeless. Treatment is expensive, residential stays are short (often, no more than 28 days), and, without adequate discharge planning, individuals frequently return to the streets (McMurray-Avila, 2001). People with substance use disorders in day treatment programs may have no place to sleep at night. The combination of poverty and addiction are significant barriers to adequate housing.

Many individuals who are homeless have both substance use disorders and serious mental illnesses. A growing body of research supports the concept of integrated treatment for these individuals - that is, treatment for both disorders provided concurrently by the same clinician or team of clinicians in a single setting (Drake et. al., 1998). Such treatment is particularly beneficial in helping individuals recover from substance use (Oakley and Dennis, 1996). However, few such programs exist. The significant unmet need for both mental health and substance abuse treatment means that those with the fewest resources are least likely to receive appropriate care.

THE FEDERAL RESPONSE

Ending chronic homelessness among people with serious mental illnesses and/or co-occurring substance use disorders is an achievable goal. The Stewart B. McKinney Homeless Assistance Act of 1987 (P.L. 100-77)—known today as the McKinney-Vento Act—was the first and, to date, the only comprehensive Federal legislation to address homelessness. The Act included a number of provisions designed specifically to provide health and mental health care to people with serious mental illnesses and substance use disorders who are homeless.

Amendments to the McKinney Act—made in 1988, 1990, 1992, and 1994—for the most part, have strengthened the provisions and expanded the scope of the original legislation (National Coalition for the homeless, 1999). Since enactment of the McKinney Act, the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services, and the U.S. Department of Housing and Urban Development, have funded innovative housing and service programs, and research and demonstration projects to determine how best to serve people with serious mental illnesses and substance use disorders who are homeless. These programs served as a catalyst for further development of the evidence-based practices presented in this report.

A FRAMEWORK FOR SERVICES

The McKinney Act also established the Interagency Council on the Homeless (now the Interagency Council on Homelessness) to provide federal leadership for activity's to help homeless individuals and families. Comprised of the heads of major Federal departments that manage programs for people who are homeless, the Council convened the Federal Task Force on Homelessness and Severe Mental Illness in the early 1990s. When the Task Force released its 1992 report, *Outcasts on Main Street* it provided a national strategy and a comprehensive framework for addressing homelessness among people with serious mental illnesses, many of whom have substance use disorders.

In particular, the Task Force recommended that Federal agencies help states and local communities develop *integrated systems of treatment, housing, and support services for people with serious mental illnesses who are homeless*. The framework for services outlined in *Outcasts on Main Street*—which included such key elements as outreach, case management, and a range of housing options - has withstood the test of time and rigorous evaluation, not

only for people with serious mental illnesses but also for those with substance use disorders and co-occurring mental illnesses and substance use disorders, as well.

Federal demonstration programs and the experience of hundreds of community-based providers, have demonstrated that residential stability is a goal desired by, and attainable for, most people with serious mental illnesses and substance use disorders who become homeless.

UNDERSTANDING THE POPULATION

Research and practice reveal that communities can reach out to people with serious mental illnesses and substance use disorders; engage them in treatment; and create local partnerships to increase availability and access to affordable housing, employment, and treatment and supports to help prevent and end homelessness. Understanding how to do so; however, begins with knowledge about why people with serious mental illnesses and substance use disorders are vulnerable to becoming homeless and why they have a difficult time exiting homelessness.

11.2 Homelessness Key

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