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Psychiatric Medical Care and Safe Housing for Mentally Ill Homeless

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Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Due to the deinstitutionalization movement, many mentally ill individuals have left asylum treatment centers and have had no safe housing. The purpose of this grounded theory study was to explore the attitudes and opinions of homeless, mentally ill people regarding the community resources they consume and how they perceive and navigate those resources. The research questions focused on homeless, mentally ill individuals' shared experiences accessing health care, psychiatric care, and housing services as well as, barriers that impacted homeless, mentally ill individuals' use of these services, and their needs to address these barriers. Data were collected using face to face, semi structed interviews with 12 homeless individuals. The thematic analysis consisted of open and axial coding. Axial coding was used to assign and like categories and subcategories of codes according to their properties and dimensions. Emergent patterns were identified from the data to explain the lived experiences of mentally ill homeless people and their opinion and attitudes towards navigating of mentally ill homeless programs. The responses expressed the needs that were unmet: lack of mental health assistance, food needs, hygiene needs, safety concerns and survival needs. In order to make positive social change outreach predicated on increasing clear communication between outreach workers and the homeless mentally ill allows for developing a trusting relationship necessary in establishing contact and credibility in providing on going impactful treatment for the homeless mentally ill population.

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Dedication

I know without Jesus this journey would never have come together. "I can do all things through Christ who strengthens me." Philippians 4:13.

This dissertation is dedicated first and foremost to my 12 participants who shared of their lived experiences in hopes of making positive social change. To my mother who must be celebrating in heaven, because I know she is proud of me.

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Chapter 1: Introduction to the Study

Homelessness, mental illness, and access to medical treatment are problems in U.S. society. To remove the obstacles preventing the homeless and mentally ill from accessing housing and medical services, mental health officials must first identify those obstacles. In this study, I interviewed individuals who personally experienced both homelessness and mental illness to understand the barriers they faced accessing beneficial services. I conducted a grounded theory study to investigate how participants viewed the issues of access to shelter and access to psychiatric and medical care to gather participants' real-life experiences. In this chapter, I will provide a history of homelessness and mental illness, followed by known barriers to accessing community resources. By understanding the issues surrounding access to shelter and care from the consumer perspective, mental health workers can provide these services and improve the lives of homeless people with mental illnesses.

Background

Homelessness and mental illness have always existed in the United States (Fakhoury, Murray, Shepherd, & Priebe, 2002; Lamberti et al., 2001; Rossi, 1990). Treatment employed to address mental illness and reintegrate homeless persons have varied throughout U.S. history (Dixon & Goldman, 2004; Grob, 1983; Johnson, 1990; Luchins, 2001). By the 1950s, mistreatment of patients, poor results, budget cuts, overcrowding, and advances in drug therapy contributed to a new movement to shrink the existing system and move patients out of asylums and into the community (Johnson,

1990). The shrinkage of the residential system perpetuated by these factors came to be termed deinstitutionalization.

Two major waves of deinstitutionalization took place in the United States, the first during the 1950s and 1960s and the second during the 1970s and 1980s (Johnson, 1990). The first wave resulted from advances in psychotropic drugs (Gronfein, 1985), and the second from increased social planning measures. such as Supplemental Security Income instituted in 1974 (Rosenheck, Frisman, & Kasprow, 1999) as well as the integration of mental health care services in hospitals (Boardman, 2006). As society began to reject large-population asylums in the 1960s, community mental health centers were outfitted to treat a large volume of new patients who had previously been hospitalized. These centers were given federal funding and formed a prevailing ideology that mixed early emphasis on prevention and treatment of acute cases with the ability to deliver the services of a state hospital. The new model "required five services: inpatient, outpatient, partial hospitalization, emergency, and consultation-education services" (Dixon & Goldman, 2004, p. 383). The centers did not focus on this released population and served mostly new patients, partially because of laws that either did not foster or actively prevent coordination between state hospitals and centers.

The effects of deinstitutionalization have altered how mental care systems and homeless care systems function in the United States. According to registries, in 1960, roughly 563,000 beds were available nationally with 535,400 resident patients (Markowitz, 2006). By 1990, there were 98,800 beds available, with 92,000 resident patients (Markowitz, 2006). Deinstitutionalization and care in the community became

linked with a growing population of mentally ill, homeless people. Community support programs targeting the chronically ill provided mentally ill, homeless people with work, housing, and treatment, yet could not meet needs of the number of chronically mentally ill people.

The development and implementation of evidence-based practices helped to address the mentally ill homeless, which resulted in the development of Assertive Community Treatment (ACT), a system that offers the most effective and efficient treatments, rehabilitation, and support services in the community. The ACT resulted from an earlier program, the Training in Community Living Model, that taught patients the behaviors and strategies they would need to cope with living in society. This program had verifiable success. However, in some areas, ACT programs have not had successful results since the 1990s, perhaps due to shifts in program elements away from the classic ACT program. It is unknown if ACT services help a patient to make or maintain gains and whether a patient can be removed from ACT without regression.

In a period of postdeinstitutionalization, the asylum model is no longer the normal treatment for mentally ill people. Although deinstitutionalization solved some of the problems of the institutional system of care (e.g., overcrowding, abuse), new problems have come to the surface. Upon their release from the asylum, patients often became lost in the larger society and fail to navigate successfully the fragmented network of mental health and public welfare alternatives (Manderscheid et al., 2010). From the 1950s to the mid-1980s, despite the development of programs, many communities lacked the resources, organizations, and infrastructure to deal with resident expatients

(Manderscheid et al., 2010). The streets and prisons subsequently became home to the mentally ill, homeless population (Markowitz, 2006), and increasing levels of homeless mentally ill became visible by the early 1980s (Rosenheck et al., 1999). The combination of fragmentation of services and deinstitutionalization exacerbated the problem of the homeless mentally ill. The prevalence of psychosis, depression, and personality disorders is higher among the homeless population than in the general population (Fazel, Khosla, Doll, & Geddes, 2008).

Problem Statement

It is difficult for people who are homeless and mentally ill to navigate the complex, bureaucratic social structures established to help them; these are structures they often distrust (Daiski, 2007; Rosenheck et al., 1999; Smith & Sederer, 2009). Little qualitative investigation has been conducted on how homeless, mentally ill individuals access services and the difficulties they experience in doing so. Furthermore, health, shelter, and mental health professionals may have difficulty coordinating care for patients or consumers in the community (McCrea & Spravka, 2008). Different professionals see the homeless mentally ill from diverse perspectives—physical health, mental health, and the shelter (housing). However, none of these perspectives alone describes the needs, hopes, and goals of homeless, mentally ill individuals. The focus of this study was on how homeless, mentally ill individuals reconcile these different services and perspectives.

Purpose of the Study

The purpose of this study was to gather the opinions and experiences of individuals who are mentally ill and homeless concerning their navigation of existing

medical, mental health care, and housing programs. Homeless shelters, mental health institutions, hospitals, and prisons have implemented diverse approaches to service provision. These programs have not been problem-free, and construction of holistic care remains difficult to achieve (McQuistion, Finnerty, Hirschowitz, & Susser, 2003). One potential path towards improvement that has received less attention in the literature is through the examination of clients' opinions.

Although scholars have examined homeless, mentally ill individuals (Daiski, 2007; McCrea & Spravka, 2008), these researchers have focused on patients' perceptions of quality and effectiveness or their goals. Through the use of client feedback, I examined the concept of access to determine how homeless, mentally ill individuals navigate existing housing, physical health, and mental health systems, with the intent of improving ease of access to services. Understanding homeless, mentally ill individuals' views will provide insight into the user experience of integrated housing, health, and psychological care solutions that exist in San Antonio, Texas. This information may reveal the following: (a) areas requiring improvement; (b) homeless, mentally ill individuals' actual goals (as opposed to what care professionals believe their goals are); and (c) organizational strategies that may improve consumers' outcomes and access to services and decrease bureaucratic complexity.

Research Questions

Although qualitative, grounded theory research is not driven by a priori hypotheses, it is guided by overarching research questions. These questions guided the interview process, which aimed to solicit homeless, mentally ill individuals' opinions on

homelessness and mental illness. The following overarching research questions guided this study:

1. From their own perspectives, what are homeless, mentally ill individuals' experiences accessing health care, psychiatric care, and housing services?

2. What barriers have impacted homeless, mentally ill individuals' use of these services, and what do they think is needed to address these barriers?

Theoretical/Conceptual Framework

Grounded theory (Glaser & Strauss, 1967) was the theoretical foundation for this study. In grounded theory, the researcher first collects data and then forms hypotheses from the analysis of the data. This process follows a research paradigm opposite to the standard scientific model, which states that a researcher must first propose a theory and then test it against empirical evidence. Grounded theory affords the researcher the flexibility necessary to focus on participants in their natural settings. I collected data through semistructured, one-on-one interviews with clients. I then analyzed and sorted data into relevant categories. These categories depended on the data and the relationship between clients' answers and the research questions. From the categorized data, I formed hypotheses concerning the improvement of care and access to care for this segment of clients. The grounded theory design was appropriate for this study because it allows for the use of experiences, opinions, and nonobjective perceptions of the individual, which were used to generate new theory grounded in participants' shared experiences. In qualitative research, the primary interest is to gain an understanding of identified

situations from individual perspectives, rather than to explain or predict behaviors that may occur in the future.

The Nature of the Study

In this qualitative study, I interviewed 12 homeless individuals. According to Guest, Bunce, and Johnson (as cited in Charmaz, 2014) "12 interviews suffice for most researchers when they aim to discern themes concerning common views and experiences among relatively homogeneous people" (p. 107). Saturation was achieved when interviewing additional participants yielded no new themes. All participants had a diagnosis of an Axis I clinical mental disorder, such as schizophrenia or other psychotic disorders, mood disorders (depression, bipolar),or anxiety disorders according to the *Diagnostic and Statistical Manual of Mental Disorder*, Fourth Edition (American Psychiatric Association, 2000), as identified by staff at local shelters or self-reported by those interviewed. I conducted semistructured, individual interviews to collect data, asking questions that assess the access of the homeless individual to shelter, mental health, and medical services. I asked participants to direct follow-up questions to each of the standardized questions. In the event that participants' access to service was difficult, obstructed, or lacking, I asked questions concerning their perceived reasons for this and what they would do to improve access.

Definitions

Consumers/clients: Homeless people who want to use health, psychological, and housing solutions provided by the institutions, either public or private.

*Health solutions***:** The provision of services, such as wellness exams and treatment, for identified medical or mental illnesses that engage everyone with dignity and respect.

Homelessness: Although a lack of clarity exists concerning the definition of the term (Fazel et al., 2008; Herrman, 2008), homeless features the

lack of appropriate housing and the social marginalization of the individual. . . . Also important is the recognition that people may be transiently, episodically or chronically homeless and that entry to or exit from the homeless state is usually part of a process rather than a single jump. (Herrman, 2008, p. 1641)

Housing solutions: The provision of safe housing for the homeless, mentally ill population.

Assumptions

In this study, I assumed that participants dealing with homelessness have crossed all barriers involved with their care. I also assumed that participants will be able to reflect on their experiences and communicate about further appropriate care.

Scope and Delimitations

In this study, I explored how 12 homeless individuals who had Axis I diagnoses articulated how barriers interfere with access to psychiatric care, medical care, and stable housing.

Limitations

Potential problems included participants who may choose not to complete the interview or those who may be eliminated from the study for various reasons. If

participants presented with illegal drug or alcohol addictions, this could interfere with the purpose of the study. Ignoring possible biases could interfere with building trust with participants. The results of this study can be generalized to persons who work with this population. However, this study occurred in San Antonio, Texas and may not be applicable to other states. In addition, cultural and socioeconomic disparities may provide insight into the experiences of mentally ill homeless population in their own words.

Significance

To achieve positive social change, the lack of knowledge about clients' perceptions of access to psychiatric and medical care and safe housing needs to be addressed in the literature. Access affects professionals' abilities to improve existing modes of service (i.e., physical health, psychological health, and shelter) while taking into account clients' views.

Summary

Homelessness and mental illness have been social issues in the United States. The deinstitutionalization movement; motivated by public awakening to a lack of progress in asylums, budgetary concerns, and advances in psychotropic medications; resulted in the discharge of large numbers of mentally ill patients into the community. This discharge of patients; combined with fragmented community care alternatives, few low-wage jobs, and a decline in affordable housing; contributed to the issue of the homeless mentally ill (National Coalition for the Homeless [NCH], 2009c). The opinions of the homeless mentally ill may provide a path to improve service quality, effectiveness, and access for this population. In this qualitative study, I aimed to identify areas for improvement by

surveying homeless mentally ill individuals' attitudes and opinions concerning their

access to and user experience of available services.

Chapter 2: Literature Review

Introduction

Treatment and rehabilitation methods for the homeless mentally ill have varied over time. The institutional model was the primary treatment modality until the 1950s. During and following deinstitutionalization, care in the community became the chief method of delivery. Care in the community was not always well coordinated, which resulted in a lack of follow-up with many consumers. These consumers swelled the ranks of the homeless mentally ill; this population found it difficult to obtain stable housing situations partially because of their mental illness, and partially due to other factors such as the lack of affordable housing alternatives (Forchuk, Russell, Kingston-MacClure, Turner, & Dill, 2006). A lack of coordination is still a problem that needs resolution (Forchuk et al., 2006). One established method of identifying difficulties in access is to ask consumers directly about their experiences (Herrman, 2008). Understanding the problem of the homeless mentally ill from the perspective of the consumers is key to solving problems of service access, quality, and integration. To better understand the relationship between the homeless, mentally ill population and the services that they consume, it was necessary to first review the available research on this group, their opinions, and available community care alternatives.

Literature Search

I conducted an electronic literature search through Walden University, the EBSCO database, and Yahoo and Google search engines. Search terms included *homeless*, *mentally ill*, *questionnaire*, *attitudes and beliefs*, *community care*,

deinstitutionalization, and *homelessness trends*. The goal was to identify as much of the literature as possible that related to the topic at hand, and from that maximum pool of research, select articles that were germane. Much of the research found was not germane to the current question. Other published material was germane but not current. A review of this literature reflects thinking on the topic of the homeless mentally ill over time, illustrates that there are gaps in the literature on this topic, and provides insight into the experiences of the homeless mentally ill.

Definitions of Homelessness

U.S. law defined a homeless person as a roofless person (NCH, 2009b) who does not have a fixed domicile or is about to lose his or her domicile within a week. This person may not be incarcerated but may be a resident in public or private shelters. Although homelessness as rooflessness provides a legal definition, it is not without its problems (NCH, 2009b). The NCH (2009a) pointed out some of the problems with the legal definition. For example, there is an overemphasis on clearly visible roofless persons. In rural areas, homelessness is less visible because it is not composed entirely of persons living outside or in a shelter, as there are usually no shelters in rural areas (NCH, 2009a). Rather, those in rural areas stay with relatives or in substandard or crowded housing alternatives, and thus are undercounted (NCH, 2009a). The NCH (2009b) found that homelessness is a temporary state for many people, and it consists of a population undercounted by censuses that only count use of shelter and soup kitchen services.

A more inclusive and accurate definition of the homeless includes people who do not have stable housing solutions in their life. The homeless are people who have lost

their residence and are roofless, are floating from temporary solution to temporary

solution, or are living in unacceptable conditions that are overcrowded or substandard

due to their inability to secure acceptable, stable housing. As such, the working definition

of the homeless in this study was the following: those who are roofless or living in highly

precarious circumstances, which include substandard or overcrowded housing.

Background of the Problem: General Homelessness

The National Law Center on Homelessness and Poverty (2012) estimated that 3

million people in the United States are homeless at one point or another during any given

year, with 1.3 million of those individuals being children. Kotch (2009) estimated that 1.6

million persons use transitional or emergency shelters during a given year. The NCH

(2009a) also estimated that on a single day, 744,313 people use these services. These

scholars show the difficulty of accurately calculating how many homeless people exist in

the United States at a given time, which may be related to the definition of homelessness.

Some people experience acute homelessness and may temporarily live in their cars, drift

from one friend's house to another, or may have short spells of being roofless (NCH,

2009b). This population is less likely to use shelter and food kitchen resources than other

populations and, therefore, will not be fully captured by 1-day snapshots like the National

Alliance to End Homelessness' 1-day service headcount (NCH, 2009a). The transitory

homeless or those in precarious living conditions may be turned away from shelters as

well (NCH, 2009a). Other homeless people are chronically homeless, roofless persons

who sleep outside or on the streets (NCH, 2009a). The chronically homeless are more

likely to use shelter and food kitchen resources and experience high levels of severe mental illness and substance abuse (NCH, 2009a).

There are also factors that make it difficult to determine the full number of chronically homeless people by typical headcount metric strategies. For example, shelters have a limited capacity, with many shelters having to turn away as much as 75% of its applicants in any given day (NCH, 2009a). In addition, in shelters there is usually a fixed maximum length of stay, and once this stay has been reached, the consumer must leave the premises (NCH, 2009a). Therefore, consumers who were at a shelter and counted at one point in time may find themselves out on the street at another point in time, and as a result, be uncounted by a census of the homeless, although the consumer was homeless before, after, and during residence in the shelter. Nickasch and Marnocha (2009) reported that participants identified having an external locus of control. Since 2007, levels of homelessness in general—and particularly levels of homeless children—have been rising. This has been measured through bed capacity in shelters (Kotch, 2009; NCH, 2009a). The homeless population is increasing.

Homelessness and Mental Illness

The prevalence of mental illness among the homeless is hard to verify. Calculating the number of mentally ill homeless is subject first to the general metric difficulties already mentioned, such as the establishment of a sufficiently inclusive definition of homelessness, as well as the establishment of a means of tabulation appropriate for the definition. Available estimates of the number of homeless mentally ill from various sources differ. For example, Fazel et al. (2008) reviewed data from different

surveys of the homeless to report the average prevalence of mental illness. The reported

prevalence of psychosis in these studies was 12.7%; however, estimates "ranged from

2.8% to 43.0% with substantial heterogeneity among the estimates" (Fazel et al., 2008, p.

1,641). Major depression, on average, was prevalent in 11.4% of the population with

estimates ranging from 0% to 40.9% (Fazel et al., 2008).

Stergiopoulos, Dewa, Rouleau, Yoder, and Chau (2008) reviewed clients referred

to an integrated care network (mental and physical health) and found that 55% of 73

referred patients "had a previous psychiatric hospitalization" (p. 62). Stergiopoulos et al.

further estimated that in the homeless population in general, "between one-fourth and

one-third of the homeless has a serious mental illness, such as schizophrenia, major

depressive disorder, or bipolar effective disorder" (p. 62). Vamvakis and Rowe (2001)

estimated that psychosis and affective disorder is present in 20–25% of all homeless

clients. Point of prevalence counts also tend to count more mentally ill individuals as

homeless (NCH, 2009a; Phelan & Link, 1999), indicating that mentally ill homeless

people are more chronically homeless.

The reasons for the positive correlation between mental illness and homelessness

are not universally agreed upon, and not all scholars believe that deinstitutionalization is

at fault (Dixon & Goldman, 2004; Herrman, 2008; Mojitabai, 2005; NCH, 2009a). For

example, some homeless patients perceive their loss of a home as the result of common

social or financial problems, not as the result of their mental illness (Mojitabai, 2005).

Dixon and Goldman (2004) stated that releasing patients from inpatient care was not the

cause of homelessness alone, but that the resources to help patients adjust to the community was not adequately prepared.

Changing Notions of Mental Illness

Goldman and Grob (2006) examined how the changing definition of mental illness has been applied through policy in different circumstances across history. Goldman and Grob noted that in the United States, 5.4% of the general population suffers from a serious mental illness, and 2.4% of the overall population has "severe and persistent" mental illness (p. 740). The application of the label mental illness has varied throughout history, as policy initiatives have often had specific definitions of mental illness attached to them. The conflict inherent in these different definitions has involved inclusiveness and resource allocation, with a trend to either target broad categories (i.e., all types of mental illness including prevention measures) or narrow categories (e.g., focusing on the severely mentally ill; Goldman & Grob, 2006). Over time, the trend has focused resources on a narrow definition, targeting severely and persistently mentally ill people.

The roots of this shift originate from a directive issued by President Carter in 1978 to create a national plan for the care of the severe and persistent mentally ill population (Goldman & Grob, 2006). Carter's plan modified existing general care structures (ie., SSI, SSDI, Medicaid, and Medicare) to form a new network of support for severely and persistently mentally ill people in the community. Medicaid and Medicare bore the brunt of the costs for plan modifications, while SSI and SSDI provided income to mentally ill individuals. The proposed changes of Carter's plan were largely

implemented in the 1980s despite the change of government under Reagan. Depending on the nature of the disease, mental services were sometimes mainstreamed with physical health programs and other times separated until 2005 (Goldman & Grob, 2006). Laws passed in 1998 further aggravated this problem of pigeonholing patients by their diagnosis, making federal payment for individual episodes of care dependent on medical necessity.

The addition of the medical necessity component resulted from concern that minor conditions, such as jet lag, would waste public funds (Goldman & Grob, 2006). Goldman and Grob (2006) argued that managed care may be the best alternative to diagnosis-based payment, which is arbitrary and restrictive. Currently, mental illness is defined by the Surgeon General (1999) as diagnosable "conditions that are characterized by alterations in thinking, mood or behavior…associated with distress and/or impaired functioning" (p. 5) This definition, along with a focus on those with severe and persistent mental illness, characterizes the rubric used by mental health organizations in the United States.

Manderscheid et al. (2010) also reviewed the evolving definitions of mental illness and wellness and the role these definitions play in public health policy. During much of the 20th century, mental illness was consistent with the existence of a mental disorder in the patient. Mental wellness was the absence of a disorder. Mental wellness and illness existed as two points along a single continuum, with the emphasis of the medical establishment placed on the identification and treatment of illness. During the 1960s and 1970s, patients were defined by their particular diagnoses with little room for

"broad classes of mental disorders" (Manderscheid et al., 2010, p. 2). In the 1980s and 1990s, as patients were discharged in the final large wave of deinstitutionalization, the homeless, mentally ill population surged, and community resources became insufficient to support their needs. Disability is defined as the inability of the patient to carry out activities (Manderscheid et al., 2010).

Duration defines the scope of a mental illness in a patient, with a time not less than 1 year being the requirement for a person to qualify for services (Manderscheid et al., 2010). The creation of these categories led to the severely and persistently mentally ill population (Manderscheid et al., 2010). Wellness and illness came to be considered as existing in two different continua: wellness was not the absence of disease but a positive feeling about life, happiness, and meaning, and positive but realistic feelings of personal capacity.

A lack of these feelings is detrimental to the physical health of the patient. For example, the life expectancy of those suffering from mental illness and under public treatment is 25 years lower than the healthy population (Manderscheid et al., 2010). Manderscheid et al. (2010) noted that the focus of treatment has become the promotion of mental wellbeing while, at the same time, pursuing reintegration and participation in society. Manderscheid et al. recommend further research and documentation of the mind–body link, as well as pursuing greater integration of psychological and physical health care services.

Relevancy, Actuality, and Significance of the Problem

Homelessness, mentally ill clients require a continuum of services that are different from nonmentally ill clients. These services may include outpatient psychiatric care, medication, substance abuse treatment, and medical treatment. A high percentage of mentally ill homeless clients experience cooccurring substance abuse problems and, subsequently, may have more serious and frequent health ailments that often result in a higher mortality rate (Boardman, 2006; Christensen et al., 2005; Fazel et al., 2008; North, Thompson, Pollio, Ricci, & Smith, 1997; Rosenheck et al., 1999; Vamvakas & Rowe, 2001). Furthermore, homeless, mentally ill individuals use shelter resources more than those who are not mentally ill (NCH, 2009a). Finding and putting into practice successful strategies for the creation of a continuum of care for mentally ill, homeless clients may positively impact a significant percentage of the homeless population. Understanding how mentally ill, homeless clients perceive, use, and interact with the health, shelter, and psychological systems available to them may help to create better systems of service.

The Number of Homeless

Homeless populations experience a high turnover. Many people enter and exit a period of homelessness in their lives and never use shelter or soup kitchen services. There are two major strategies for counting the homeless. Point-in-time counts and period prevalence counts measure the transitory homeless population. Point-in-time counts measure the population that is homeless during a given time period, such as a week or single day, according to the amount of people in shelters, using soup kitchens, or who are

obviously living on the streets (NCH, 2009a). This approach is typically employed due to time and budgetary constraints. These counts are not entirely accurate because

> [they] do not accurately identify…intermittently homeless people, and therefore tend to overestimate the proportion of people who are so-called 'chronically homeless' – particularly those who suffer from severe mental illness and/or addiction disorders and therefore have a much harder time escaping homelessness and finding permanent housing. (NCH, 2009a, p. 1)

In contrast, period prevalence counts measure homelessness over longer periods of time. However, these numbers too can be unreliable, as they do not measure the "hidden homeless" (NCH, 2009a)—people who live in boxes, cars, caves, boxcars, or other locations out of public view. It is difficult to get reliable numbers regarding the amount of people who experience homelessness for any period of time.

Estimates of the homeless population range because of the difficulties and limitations described. The National Alliance to End Homelessness (2012) estimated that 671,859 people are homeless on any given night, based on a biyearly 1-night point of prevalence. Alternatively, the National Law Center on Homelessness estimated that 3 million people experience homelessness in the United States in a given year. Kotch (2009) also estimated that 1.6 million are using shelters or transitional housing. These three estimates were based on two national point-of-prevalence homeless service provider headcounts from 1996 taken in October and February (NCH, 2009a). These numbers were then annualized based on the point of prevalence data in question. The annualized figure for February yielded 3.5 million homeless individuals in the United States yearly,

while the figure for October yielded 2.3 million (NCH, 2009a). The methodology

involved reflects some of the difficulty researchers face in obtaining timely and relevant

data.

According to a survey of 23 cities, 94% of homeless individuals living on the

street were single adults, 4% were part of families, and 2% were unaccompanied minors

(U.S. Conference of Mayors as cited in NCH, 2009a). Of shelter residents, 70% were

single adults, 29% were family members, and 1% were unaccompanied minors U.S.

Conference of Mayors as cited in NCH, 2009a). Of supportive housing members, 60%

were single adults, 39.5% were family groups, and .5% were unaccompanied minors

(U.S. Conference of Mayors as cited in NCH, 2009a). The homeless population is

estimated to be 42% African American, 39% European American, 13% Hispanic

American, 4% Native American, and 2% Asian American (NCH, 2009a). This may vary

by location in the country. Twenty-six percent of the homeless are considered mentally

ill, 13% are physically disabled, 19% are victims of domestic abuse, 13% are veterans,

and 2% are HIV-positive (NCH, 2009a). Nineteen percent of the homeless are employed

(NCH, 2009a). The average stay at an emergency shelter was 51–70 days for all groups

(U.S. Conference of Mayors as cited in NCH, 2009a). In transitional housing, the average

stay was 175–223 days (U.S. Conference of Mayors as cited in NCH, 2009a). In

permanent supportive housing, the average was 556–604 days (U.S. Conference of

Mayors as cited in NCH, 2009a). Single men had the shortest average residency time in

all of these settings.

Phelan and Link (1999) examined point-of-prevalence studies and their potential for bias in describing the homeless population. Phelan and Link found that former homeless and current homeless were not the same group. Currently, among the homeless population, half had graduated from high school (Phelan & Link, 1999). Former homeless figures included two-thirds who had a history of psychiatric hospitalization (Phelan & Link, 1999). Phelan and Link concluded that extrapolating point-of-prevalence data on homelessness to generalize about the entire population leads to a picture of the homeless person as a single male minority involved in substance abuse and possessing mental problems. This portrait is more descriptive of the persistently and chronically homeless individual, who is oversampled by point-of-prevalence studies.

Homelessness Occurrence

The NCH (2009c) examined some of the causes for the appearance of homelessness in the life of the individual. Poverty and homelessness are linked (Mojitabai, 2005; NCH, 2009c). A sickness, an accident, or a missing paycheck can make the difference between having a place to live and being homeless (NCH, 2009c). Relative poverty in this population has occurred within the context of the increase in the cost of housing (NCH, 2009c). Rising costs of housing affect all groups that either are in danger of becoming homeless or are currently chronically or acutely homeless. Neither public welfare nor minimum wage employment covers the rising cost of housing (NCH, 2009c). In 2009, a worker needed to earn $14.97 per hour in a 40-hour workweek to cover a one-bedroom apartment (NCH, 2009c). The NCH (2009c) found that employment had

become more precarious and financially unrewarding for those at the lower end of the workforce, as many well-paying factory jobs no longer existed.

Like housing prices, the costs of everyday items continue to increase. Support mechanisms such as shelters, SSI, and Temporary Assistance to Needy Families (TANF) are often not sufficient to secure stable housing (NCH, 2009c). A person on SSI would not be able to afford the national average price of a one-bedroom apartment at $715 USD per month because the average SSI income is lower than this (NCH, 2009c). State programs such as SSI and TANF have not kept up with the price of housing and, at the same time, affordable housing has also dwindled. The Texas Interagency Council for the Homeless (2012) reported that in 2011, there were 7,919 homeless persons living with severe mental illness; 21.5% of homeless were extracted from the general homeless population. The Texas Interagency Council for the Homeless also indicated that the average cost of renting a two-bedroom apartment in San Antonio was $730 per month.

The NCH (2009c) did not find that deinstitutionalization was a factor in the homeless population. The primary contributing factors to homelessness are unaffordable housing, fragile and financially unrewarding workplace relations, and reduced public aid (NCH, 2009c). The NCH stated that approximately 16% of the homeless are mentally ill, although other sources contradict this (e.g., National Law Center on Homelessness and Poverty, 2012). This population does not require institutionalization, according to the U.S. Department of Health and Human Services (as cited in NCH, 2009c), and is capable of living in the community. The NCH further pointed out that deinstitutionalization occurred mostly in the 1950s and 1960s but increases in the homeless population

occurred in the 1980s. The NCH concluded that deinstitutionalization did not cause the current phenomenon of the mentally ill homeless; rather, it was a lack of access to supportive housing and/or other treatment services.

The Stigma of Homelessness

Phelan, Link, Stueve, and Moore (1997) used a vignette experiment to determine if stigma was attached to the label of homelessness. A single vignette was crafted, modified with significant phrases, and read to a subject who responded to 16 questions (Phelan et al., 1997). Stigma was defined as a social object that "discredits" and "spoils" the identity of an individual, "disqualifying [him] from full social acceptance" (Groffman as cited in Phelan et al., 1997, p. 323). Phelan et al. indicated that there was a tendency in European American culture to stigmatize the poor, ostracize them from the community, and blame them for their own situation, which was seen as a result of poor character, poor choices, and personal moral flaws. In modern times, the public has vacillated in its opinions towards the poor, being more punitive in the 1990s than in the 1980s (Phelan et al., 1997). Phelan et al. (1997) found that the label of homelessness increased social distance between respondents and the story character. Phelan et al. stated that homeless people are likely to face social stigma, blame, and discrimination in housing, employment, and relationships because of their social status—difficulties that add to the obstacle of being homeless and likely lead to the perpetuation of homelessness.

Sources, Numbers, and Percentages

The link between mental health problems and incidence of homelessness has been represented in the literature. Forchuk et al. (2006) examined how often psychiatric wards

discharge patients to a shelter or to no address. Shelters are often not appropriate places for people who have been recently discharged on psychotropic medications, as they may be exposed to substance abuse, lack of privacy, and a low staff-to-client ratio (Forchuk et al., 2006). Goering, Tolomiczenko, Shelton, Boydell, and Wasylyna (2002) found that 64% of first-time shelter residents had substance abuse problems and 64% also had other mental health problems. Among multiple-time shelter users, 71% had substance abuse problems and 69% had other mental problems (Goering et al., 2002).

Research on the link between mental hospital discharge and homelessness is relatively scarce, and though the homeless mentally ill are known to be overrepresented, homelessness is not usually associated with time to hospital discharge. Hospital data showed there were 167 recorded instances of release to the shelter or to the street (Forchuk et al., 2006). Shelter data showed that there were 194 instances of discharge from psychiatric hospitals directly to the shelter (Forchuk et al., 2006). Forchuk et al. (2006) concluded that of all discharges, 11.6% in the first year and 7.6% in the second year were directly to a shelter. Forchuk et al. indicated that shelters are not appropriate places for recovery from mental illness. Forchuk et al. suggested that practitioners need to assess the housing stability of patients, take steps to get housing for patients if possible, and acknowledge that release from shelters to the streets is a problem that should not be ignored.

Fazel et al. (2008) reviewed professional literature to ascertain the percentage of mentally ill homeless people in the larger homeless population. The most common mental disorders in the homeless are alcohol and drug dependence (Fazel et al., 2008).

Further, psychosis and depression in this population have comparable levels of prevalence. Fazel et al. noted that the estimates for serious mental disorders were high and suggested local providers should estimate their local prevalence and act on this information. Fazel et al. recommended integration of treatment for mental illness and substance abuse, combined with housing interventions.

North et al. (1997) aimed to show what, if any, mental illness diagnoses were more common in the homeless mental health clinic attendees as compared to domiciled attendees. First, prevalence of schizophrenia, somatization disorder, and bipolar disorder were not statistically different between groups (North et al., 1997). Second, depression and nonantisocial personality disorder were more common in domiciled patients (for depression: 16.7% vs. 64.7% in men; 37.3% vs. 48.0% in women; for personality disorders other than antisocial: 41.7% vs. 70.0% in men, 60.0% vs. 62.2% in women; North et al., 1997). Finally, prevalence of antisocial personality disorder and substance abuse were more common in homeless clients. Women displayed higher rates of drug abuse, and men displayed higher rates of alcohol abuse (North et al., 1997). North et al. recommended that practitioners examine patients for substance abuse and antisocial personality disorder when assessing the mental health care needs of homeless patients, although these disorders are more difficult to diagnose in single interview sessions.

Burns, Robins, Hodge, and Holmes (2009) investigated the persistently homeless individual who has received intensive mental health care treatment in the community and the number of these individuals in the urban area around Melbourne, Australia. Burns et al. found that substance abuse was comorbid in 53.1% of all men and was the most

common comorbid illness. Burns et al. stated that the "documentation of these men . . . represents evidence as to the limits of our current service system" (p. 129). Burns et al. indicated that current modalities of treatment of mental illness in the community and reintegration are not sufficient to help this minority of men. Burns et al. pointed out that men who are mentally ill and homeless for a long period of time have a complex mix of disabilities that complicates their treatment and reintegration into society, and about half reported inability to manage their finances. Burns et al. also reported that a minority of men who are homeless and diagnosed with long-term psychosis do not respond to treatment in the community. Diverse difficulties in different areas of function may contribute to overall problems with reintegration and follow-up to treatment. Burns et al. recommended that this subset of patients demands "management and supported accommodation," as community outreach delivered on an opportunistic basis is not sufficient for this population.

Service Models and Theory

Establishing empirical evidence on barrier-free health care may lead to a reduction in prejudice and discrimination. Vamvakis and Rowe (2001) examined a case study of a shelter and how it implemented mental health training in its staff. Vamvakis gave lessons to the nine case managers (CMs) at the shelter. The second class of worker consisted of residential supervisors (RSs), who were not trained by Vamvakis. After training, RSs complained that their disciplinary discharges (when a consumer was ordered to leave the shelter for a few days because of bad discipline) were remanded by CMs who said they were being too harsh and not understanding the clients enough.

Vamvakis and Rowe concluded that training only one group caused needless tension, noting that some patients were not unwilling to follow rules but were unable to because of mental difficulties. After training RSs, personnel experienced positive gains in confidence and in making independent decisions and came to have a better relationship with CMs. After training, disciplinary discharges for both classes of workers decreased. Vamvakis and Rowe stated that they did not aim to turn shelters into treatment centers but deemed it important to have some level of care there available for consumers who need it.

Vamvakis and Rowe (2001) further stated that trainers who attempt to give classes to shelter personnel have to be aware of the organizational structure of the shelter and potential conflicts or racial tensions that may exist between work groups. In addition, trainers need to be aware of the overall skepticism of all groups toward mental health organizations, which are perceived as a potentially destabilizing force (Vamvakis & Rowe, 2001). Vamvakis and Rowe concluded that training for staff is worthwhile, will strengthen staff confidence, allow staff to better service consumers, and enable staff to be more aware of mental health issues when they appear. Vamvakis and Rowe stressed, however, that training must take place within the context of the shelter organization and structure and include cooperation between all staff levels to promote success.

Newman and Goldman (2008) examined existing literature regarding the effectiveness of and access to housing programs available to mentally ill homeless consumers. Newman and Goldman explained that normalization, where mentally ill homeless are treated the same as other consumers, is a potential cause of poorer outcomes

because homeless consumers are often lost in bureaucracy. Furthermore, public housing

programs that do not take mental illness into account often place homeless people in

situations that are not optimal for their reintegration or recovery (Newman & Goldman,

2008). One example of a program focused on the mentally ill homeless consumer is HUD

Section 811, which subsidizes group homes for fewer than eight people or independent

living arrangements in buildings with fewer than 20 tenants. Newman and Goldman

stated that some homeless, mentally ill individuals are able to secure housing and keep it

with minimal support, as evidenced by some successes in unfocused housing programs

that include the mentally ill. Newman and Goldman also noted a high level of complaints

of discrimination from property owners reported by mentally ill consumers to HUD.

Newman and Goldman also observed that some case management styles produce positive

results, but comparison of those styles remains difficult due to lack of information.

Newman and Goldman recommended a refocusing of research priorities around housing

effectiveness, access, and case management to formulate evidence-based procedures in

the future.

Interventions: Service Delivery and Integration

Muir, Fisher, Dadich, and Abelló (2008) examined the performance of the Mental

Health Housing and Accommodation Support Initiative (HASI), an experimental housing

and treatment strategy for the homeless mentally ill in Australia. The purpose of HASI

was to give consumers an opportunity to integrate into their respective communities to

the largest degree possible through individualized housing with support (Muir et al.,

2008). Muir et al. found that most patients in HASI suffered from schizophrenia (74.3%)

or schizoaffective disorder (11.9%), were male (67.3%), and were born in Australia (93.6%). Muir et al. showed that 70% of clients remained in the housing provided by the program after 1 year, while 15% had changed locations but remained stably housed. The remaining 15% could not be tracked. High positive housing incomes were associated with the selection of the premises of housing, "taking into account locations where social networks were accessible, social setting, and services and resources" (Muir et al., 2008, p. 273). Ninety-four clients were "satisfied or very satisfied with their homes" (Muir et al., 2008, p. 273). Clients received support from workers and housing providers and displayed care of their homes, as well as good relations with neighbors (Muir et al., 2008). Mental health for clients improved, with 84% of clients spending less time in a mental hospital after HASI (Muir et al., 2008); this additional support resulted in significant cost savings. Muir et al. found that clients reported personal wellbeing first increased then decreased in Phase 3. Muir et al. (2008) stated that this was due to elation associated with independence followed by melancholy when consumers reflected on missed opportunities and looming challenges in life ahead. Sixty percent of longitudinal study consumers reported improved physical health (Muir et al., 2008). By the mid-1990s, access to physicians and mental health personnel increased. Social exclusion was minimized as the study advanced through phases, as numbers of consumers with no friends became lower, and more consumers found employment or initiated education (Muir et al., 2008). Muir et al. concluded that HASI was successful because of its service integration and the realization that some consumers need permanent and not transitional housing schemes that give them enough independence and access to interventions. Muir

et al. deemed HASI successful because it eradicated some of the barriers facing the mentally ill homeless to inclusion and participation in the community.

Nelson, Aubry, and Lafrance (2007) reviewed literature regarding the effectiveness of two housing interventions with mentally ill homeless people: Active Community Treatment (ACT) and Intensive Case Management (ICM). All programs aimed to increase consumer autonomy, recovery, and integration. Of the six studies that compared permanent housing and support with standard treatment, there was a greater increase in housing in those who participated in permanent housing with support programs, with an effect size margin of .67 (Nelson et al., 2007). Three studies compared case management and housing to case management alone; in these studies, case management and housing obtained superior results with an effect size margin of .37 (Nelson et al., 2007). In all cases comparing ACT to standard treatment methodologies, ACT produced superior housing suitability. Across eight directly experimental studies, the effect size was .47 (Nelson et al., 2007). Three directly comparable studies of ICM showed that this intervention produced superior housing outcomes when compared to standard treatment. Both ACT and ICM were effective in decreasing hospitalizations for psychiatric problems (Nelson et al., 2007). The ACT consumers had significantly more contact with other health services personnel than those in standard treatment. Nelson et al. concluded that ACT and ICM were both successful in fostering superior housing and other positive outcomes (e.g., integration, satisfaction, and medical care use) for mentally ill, homeless individuals when compared to standard treatment.

Service Results

The public often perceives care in the community for institutionalized mentally ill people as a failure. They blame this care paradigm for increases in crime, homelessness, and the general destabilization of local communities. Trieman, Leff, and Glover (1999) investigated the results of resettling long-stay psychiatric patients in the community, motivated by a spate of high-profile murders involving the mentally ill. Trieman et al. showed that of all participants after 5 years, 469 (86.9%) still lived in the community and, of those in the community, 310 (59.2%) still lived in the same home in which they were originally placed. Two hundred and one patients were readmitted at least once to a psychiatric ward (38.4%), 124 more than once, and 160 (29.7%) were long-term readmits (Trieman et al., 1999). Fifty-four patients (10.3%) were inpatients again at the end of follow-up (Trieman et al., 1999). Regarding crime, there were 15 serious assault occurrences perpetrated by 13 individuals; "nine of these assaults were on members of the public, including three sexual assaults, one attempted murder, and two muggings. Three assaults were on fellow residents and three were on staff or police officers" (Trieman et al., 1999, p. 14). Trieman et al. concluded that the community care paradigm of health care in the United Kingdom was capable of generating positive results for most of those involved in it, including stable housing and ongoing treatment with "minimal detrimental effects to society" (p. 14).

Leff (2001) examined reasons for the widespread public opinion in the United Kingdom that care of the mentally ill in the community is a failure and a factor in homelessness. Leff theorized that community care is mostly an invisible process to those

who are not involved in it. Community care buildings look like average houses, and patients and employees mostly dress and act like regular people. After deinstitutionalization, the public began to notice homeless, mentally ill people on the streets and blamed it on resettlement from institutions. Leff contended that this was not the result of resettlement but, rather, due to a decline in low-income housing during the 1980s. Leff also indicated that the majority of the homeless population had never crossed the threshold of a mental health hospital.

Another belief that contributed to a negative attitude towards care in the community was the perception of violence in the homeless population. However, Leff (2001) indicated that acts perpetrated by mentally ill people had decreased in the United Kingdom. Finally, Leff contended that well-informed members of the public and the media did not understand the complexity of modern mental health care in the community. Essentially, patients exist within a web of providers, services, and centers, each of which serves different needs. The diffuse nature of care in the community is different from the high level of centralization found in previous institutions. Leff recommended advocacy by mental health professionals to explain the system and its positive impacts, and Leff encouraged mental health professionals to promote the integration of patients into society and workplaces.

Adults with serious and persistent mental health illness (SPMI) who often are homeless have difficult or limited access to health care, with the result being a higher mortality rate. Boardman (2006) conducted a study of a health services intervention among those with SPMI attending an in-community psychological treatment facility in

Massachusetts. Boardman described many of those who suffer from SPMI as homeless or at having insufficient income, which limited their options for care. Other barriers (e.g., race, gender, and geography) also affected consumers (Boardman, 2006). Deinstitutionalization may also have had an unintentional negative effect on the physical wellbeing of expatients, as well as potential psychological patients, because it removed an institution capable of delivering an integrated package of psychological and physical care in one place. Consumers now attend community clinics that serve only the psychological dimensions of illness and are not equipped as institutions were to deliver preventative and acute medical care (Boardman, 2006).

Scholars have documented the extent to which medical illness in SPMI individuals is undiagnosed, untreated, or treated only in emergency rooms. In 1979, in a sample of 2,090 individuals in community treatment, 46% had severe physical ailments that were undiagnosed in referral (Koranyi as cited in Boardman, 2006, p. 4). Second, in 1981, 910 patients in psychiatric outpatient treatment received physicals; 20% of those included urinalysis examinations (Mueke & Krueger as cited in Boardman, 2006). Twenty-four percent exhibited some abnormality that was previously undiagnosed (Mueke & Krueger as cited in Boardman, 2006). The authors of that study recommended integrating preventative care with psychiatric care (Mueke & Krueger as cited in Boardman, 2006). Roca, Beakey, and Fisher examined 42 patients in an outpatient psychiatric recovery program and found that 92% had "at least one medical problem requiring assessment, treatment or follow-up" (as cited in Boardman, 2006, p. 4).

Researchers recommended that general psychiatric evaluations should include physical evaluations as well.

People with SPMI tend to die younger and have far earlier onset of certain serious illnesses (e.g., heart disease) than the general population (Boardman, 2006). In fact, "cardiac events in the 24–54-year-old age group were six to seven times higher [in a Department of Mental Health Study group]," compared with the general population (Boardman, 2006, p. 6). Use of certain neuroleptic medicines typically used to treat psychotic disorders was also associated with higher morbidity and mortality (Boardman, 2006). Use of such medicines has been known to cause weight gain and Type 2 diabetes, which potentially affects compliance.

Boardman (2006) examined reducing emergency room usage by 33%. The experimental group received medical care from a nurse practitioner at the behavioral care setting, while the control group continued to use their medical care as they normally did. Boardman revealed that the experimental group reduced emergency room visits by 42%, primary care practitioner contact was 50% greater, and checkups occurred with 70% more frequency. Boardman showed that patients had more access to doctors and more frequently took steps of preventative care. Boardman stated that embedding physical health care services in outpatient psychiatric care venues improves access to preventative medicine for individuals with SPMI, as well as reduces cost by eliminating expensive emergency room visits.

Young et al. (2005) examined who uses emergency services and why. Young et al. showed that 21% of respondents had a history of homelessness (41% in board and care

and 15% in a residential facility), and 86 received SSI. Schizophrenia was the primary

diagnosis for 57%, 15% were diagnosed with bipolar disorder, 4% were diagnosed with

major depression, and 2% were each diagnosed with dementia or anxiety disorder

(Young et al., 2005). Young et al. noted that persons with psychiatric disorders of greater

severity were more likely to use services. Young et al. also noted that "a history of

homelessness and lack of family contact were associated with greater use of emergency

services" (p. 163). These patients also had worse access to outpatient care, which often

resulted in noncompliance and return visits. Young et al. concluded that persons with

severe and persistent mental illness who often use emergency services tend to be

homeless and have no family support. Mentally ill, homeless people need and require

medical care, and if that need is not satisfied in the community by existing infrastructures

of care, they will turn to local emergency rooms.

Opinions of the Mentally Ill Homeless

McCrea and Spravka (2008) examined the opinions of severely mentally ill

homeless consumers regarding housing and psychological services. McCrea and Spravka

indicated that when asked about the source of their present difficulties, 63% of the

homeless mentally ill indicated that mental illness was the cause of their current

difficulties, 34% mentioned housing difficulty, 19% combined relationship and family

relationship difficulty, and 18% identified substance abuse as the main source of

difficulties. Regarding residential care modalities, clients favored counseling (74%;

McCrea & Spravka, 2008). Other services also received support, including group therapy

(50%) and help with funding (48%; McCrea & Spravka, 2008). However, other services

that clinicians view as valuable, such as follow-up with medication, were viewed as less important (45%; McCrea & Spravka, 2008). Regarding follow-up treatment, patients indicated that they would like to continue to develop and maintain relationships with care representatives that they met in treatment; 71% of patients preferred that this be at their discretion and initiated by them (McCrea & Spravka, 2008). Other alternatives were presented, including "staff calls to touch base" (favored by 54%), "participate in drop-in center" (favored by 48%) and "case management" (favored by 36%; McCrea & Spravka, 2008, p. 154). McCrea & Spravka suggested the discrepancy is due to consumers no longer viewing relationship problems as problems because they have no significant relationships left. Fifty-five percent stated that they had themselves/no one/God to rely on once they left the shelter; 36% cited a therapist or mental health staff (McCrea & Spravka, 2008). Only 23% mentioned family as support, and 12% mentioned friends (McCrea & Spravka, 2008). Lack of relationships among the homeless and the need for homeless people to have relationships that affirm autonomy and help them to participate in society are among the strongest findings of this study.

Nelson, Clarke, Febraro, and Hatzipantelis (2005) evaluated a supportive housing initiative through their experiences. Nelson et al. found that interviewees consistently described childhoods characterized by unfulfilling and unsupportive relationships. Often, interviewees reported they pulled away from social contact with friends and family and continued their lives in spirals of increasing isolation (Nelson et al., 2005). Although some interviewees experienced fulfilling and supportive social relationships, most did not. Steady employment was also elusive in the histories of most of those interviewed

(Nelson et al., 2005). Many of the interviewed reported having experienced cycles of victimization, including violence, theft, and rape (Nelson et al., 2005). After supportive housing, consumers generally reported improved quality of life. Feelings of security and safety were increased, although some still did not feel it was safe to go out at night (Nelson et al., 2005). Consumers felt that they had greater control over their lives and greater autonomy, and those with individual living arrangements felt the greatest feelings of autonomy (Nelson et al., 2005). Consumers also formed valuable and supportive relationships with other consumers, as well as staff at the housing program. Resources available to consumers were also improved, with a few noting that these housing resources were the best to which they had ever had access.

Mojitabai (2005) analyzed the perceptions of mentally ill, homeless people and the reasons for their loss of housing and continuing homelessness. Mojitabai stated that there are generally two schools of thought regarding the high levels of mental illness in the homeless population and how to reintegrate these individuals in society successfully. The first school of thought contends that intensive psychiatric treatment and treatment of substance abuse must occur first before independent housing is provided (Mojitabai, 2005). The other school of thought calls for the same strategies for the mentally ill homeless as for the general homeless: increasing housing and providing it quickly as the primary goal (Mojitabai, 2005). Mojitabai revealed that there was little difference in how the mentally ill and nonmentally ill homeless viewed the original and sustaining causes of their unemployment, which were the causes for the broad and narrow definition mentally ill homeless, as well as for the nonmentally ill. Mojitabai concluded that a general

treatment of homelessness was made by provision of housing and general social services, and not necessarily service models that link mental illness treatment to the provision of housing.

Yanos, Barrow, and Tsemberis (2004) examined challenges and opportunities in housing and community integration of the homeless mentally ill. Yanos et al. compared two differing approaches toward housing the mentally ill homeless: (a) the housing first approach and (b) the continuum of care approach. The continuum of care approach involves patients living within a staffed facility and integrates substance abuse and/or mental health treatment. Professionals decide the independence level of the patient according to what they feel he or she can manage (Yanos et al., 2004). The housing first approach places patients in independent living without integrated treatment involvement (Yanos et al., 2004). This approach has been shown to have superior tenancy outcomes and no difference in clinical outcomes (Yanos et al., 2004). Yanos et al. found that the majority of severely mentally ill people who were housed after a period of homelessness reported greater feelings of satisfaction, safety, and belonging than they had before. A significant minority of consumers from the control group felt that it was difficult to integrate into the community and had ongoing difficulties adjusting to independent living tasks. Yanos et al. noted that long-term institutionalization retards the ability of a person to live independently. Consumers reported frustration with rules and lack of privacy, which led some consumers to quit programs. In addition, patients waited longer for housing, which may have affected their feelings toward housing (Yanos et al., 2004). Yanos et al. stated that housing in the community has been successful, but mental health

professionals realize that the physical location of a place of residence may have an impact on the consumer's ability to feel comfortable as he or she may see the area as not diverse or tolerant enough.

Chapter 3: Research Method

Introduction

The purpose of this study was to research opinions of homeless, mentally ill individuals on their views concerning the barriers that keep them from accessing housing and psychiatric and medical care. Gathering first-hand experiences may improve gaps in the literature that do not consider this population's concerns. This study could lead to positive social change by improving access to services. The current study was guided by the following research questions: (a) From their own perspectives, what are consumers' experiences accessing health care, psychiatric care, and housing services? and (b) what barriers have impacted consumers' use of these services, and what do consumers think is needed to address these barriers? A qualitative research model was required to conduct first-hand interviews and personal interactions to gain subjects' trust and insights. A grounded theory approach further allowed for an exploration of participants' insights and first-hand experiences to investigate how each subject viewed his or her life.

Qualitative Research Design and Rationale

Qualitative research was appropriate to use in this study because the intention was to garner an understanding of a paradigm where little is established about the problem or variability prior to the study (Creswell, 2005). According to Flick, (2007), qualitative researchers elicit an understanding of the phenomenon by generating meanings from the experiences, feelings, and the perceptions of an individual or group. Qualitative research includes five types of designs: case study, ethnography, biography, phenomenology, and grounded theory. A biography method focuses on an individual's life without any focus

on any particular phenomenon (Flick, 2007). According to Yin (2009), in a case study method, individuals are studied with a focus on a specific topic. According to Creswell (2009), ethnography is a method that describes and interprets a social group or culture within a system. A phenomenological method is appropriate when collecting information regarding the experiences of participants in the study (Creswell, 2009).

Charmaz (2014) stated that the grounded theory design includes systematic and flexible guidelines for the collection and analyzing of qualitative data to construct theories from the data. I used grounded theory to stay involved with my interviews. Gathering the lived experiences of study participants, as well as their subjective perceptions, thoughts, and feelings about the topic of interest, will enable an understanding of the phenomenon (Flick, 2007).

Role of the Researcher

My role as a researcher was clear. I remained neutral and ensured a nonjudgmental attitude, putting all biases aside. I helped my participants achieve a level of comfort throughout the interview. I maintained all ethical standards. I sought the opinion of my chair and committee members and individual persons who work directly with my participants. I kept all my personal opinions, experiences, and prejudices dormant to prevent any negative influence on the study. I provided support as I do in my professional practice.

Participant Selection Logic

All participants identified themselves as homeless. I asked each participant for his or her age and his or her housing status prior to enrolling him or her in the study. Their

names were not recorded; instead, a number was assigned to protect their identity. Diversity in the sample was needed to reflect differences.

Instrumentation

Under the supervision of my committee members and with my knowledge gained from working with individuals living with chronic mental illness for over 25 years, I developed interview appropriate questions. I met with volunteers to get to know the sites to ensure the appropriateness of the questions. This was done after I received approval from the institutional review board (IRB).

Procedures for Recruitment and Participation

I recruited 12 participants among the Salvation Army, local churches, and soup kitchens that feed the homeless and the homeless staying in parks and on the streets. I highlighted the objectives of the study, criteria to participant, and offered $5.00 at the start of the interview and the remaining $10.00 at the end of the interview or if a participant withdraws from the interview early. I conducted a semistructured, face-to-face interview with my follow-up contact information for after the interview. The questions were piloted on two nonparticipants for validity and clarity.

Data Collection

The interviews were conducted where the individual was located (i.e., outside a shelter, in the environment where the homeless live). In San Antonio, Texas some homeless people stay at Brackenridge Park. I attempted to make contact with some of the people living in this type of setting. I approached individuals outside shelters and, with their permission, recorded the interview. The information gathered was analyzed and

sorted into relevant data categories. These categories depended on the specifics of the data and on the relationship between the clients' answers and the research questions. From categorized data, it was possible to form hypotheses for improvement of care and access to care for this segment of clients.

Interview Protocol

The interview began with the reading of the consent information. Each participant was made comfortable by offering a drink and holding a brief conversation about his or her day. At the end of the interview, information regarding support systems and housing information was given.

Obtaining Consent

The form of consent detailed the participants' right to confidentiality. The numeric identifier was placed on each signed consent form that indicates the participant accepts the terms of the study and understands the objective of the study, the research process, and the willingness to participate.

Interviewing the Participant

The interview began with a relaxed atmosphere by starting with a casual conversation. This helped to develop a rapport and build a comfort zone for both the interviewer and the interviewee. Some basic information, such as age, place of birth, cultural background, and educational level, was collected.

Data Analysis

My goal was to understand the reasons for homelessness. Verifying the responses with the participant confirmed the accuracy of the questions. Interview recordings were transcribed and then destroyed.

Coding Process

The pivotal step in the data analysis was line-by-line coding, which is the central task of grounded theory. The coding process yields highly organized and usable datasets. The data were given to a coding team who was trained in open and axial coding system of grounded theory to generate categories and themes from the data. Open coding is the process of selecting and naming categories from the analysis of the data. This was the primary level of acquiring and describing general features of the phenomenon under study (Strauss & Corbin, 1999).

Evidence of Trustworthiness

In any study, questions of quality—namely validity, reliability, and dependability—are likely to emerge. An ethical practice model is needed (Fisher, 2008). All psychologists must uphold the same ethical standards about confidentiality even though each state imposes different legal limits on their ability to protect clients' confidence. Psychologists must respect the dignity and worth of all people (APA, 2002). Working with a vulnerable population, I ensured that each participant understood the nature and extent of his or her participation. I have personal experience working with individuals diagnosed with schizophrenia, bipolar disorder, and posttraumatic stress disorder as a case manager with the Center for Health Care Services in San Antonio,

Texas. Working with clients from San Antonio state hospitals, jails, and prisons and providing support for 10–14 individuals has provided me with a first-hand experience into the lives of persons diagnosed with chronic serious mental illnesses.

Ethical Issues

Gaining the trust and support of the participant was crucial to the study. All information in the study and the informed consent was kept confidential in an undisclosed location for a specified time period, to be determined. Prior to the study, approval was obtained from the IRB. This approval ensured that ethical procedures were maintained for all participants. In the informed consent, I introduced the research process and provided contact information, the intent of the study, and the request for voluntary participation by the recipients. The participants were informed of their rights to privacy and confidentiality, and how the information was used from the study. Restricted access was based upon a need to know status.

Summary

The purpose of the study was to investigate how homeless mentally ill individuals view their access to mental health, physical wellness, and obtaining a safe place to live. Navigating the complex, bureaucratic social structures homeless mentally ill individuals often distrust will be identified (Daiski, 2007; Rosenheck et al., 1999; Smith & Sederer, 2009). The focus of my study was on discovering how individual participants view conciliation of gaps in obtainable access to community services.

Chapter 4: Results

Introduction

In this study, I explored the experiences and opinions of homeless individuals with mental illness; their perceptions of the barriers they face; and how they see their future in accessing safe housing, mental health treatment, and medical care in their own words. I chose a grounded theory approach to gather participants' individual views on how to increase their access to psychiatric and medical care, in addition to safe housing. In this chapter, I describe the qualitative analysis of the data collected and the steps involved in that analysis. This process was used to gather, generate, record, and analyze data. The overarching question that I used to guide these processes was the following: What has been missing from attempts to build bridges between disparate systems of care within the community?

My intent in the design of this research was to provide an in-depth understanding of participants' experiences and perspectives, in their own environmental settings (i.e., where they live), and to narrow a gap concerning access to community resources. This type of research is most often characterized by a concern to explore phenomena from the views of the participants in the study. To make a contribution to the existing body of qualitative knowledge, researchers should ensure that findings of their studies are trustworthy, credible, and reliable. This is obligatory as homeless individuals, with mental illness, are a vulnerable group and need as much protection as possible.

Research Questions

The primary research questions for the present study were the following:

1. From their own perspectives, what are consumers' experiences accessing

   health care, psychiatric care, and housing services?

2. What barriers have impacted consumers' use of these services, and what do

   consumers think is needed to address these barriers?

In my research, I examined how to address the gaps concerning the sharing of information. In my search for answers to these primary questions, I asked the participants the following interview questions:

RQ1: Can you give me some examples of how your illness affects your daily life?

RQ2: Have you ever tried to get help for your illness?

RQ3: Can you describe the various times that you experienced homelessness?

RQ4: What kind of things do you think contributed to you becoming homeless?

RQ5: In what ways do you think your mental illness contributed to your

   homelessness or did it?

RQ6: How did you first get diagnosed with a mental illness?

Setting

Interviews with participants were conducted over a 6-week period in San Antonio, Texas, with the intention of gaining insight by listening to homeless people who were mentally ill, as they shared their experiences of life on the streets. I spent between 50-60 minutes talking with each participant. The interviews were conducted face-to-face and audio-typed recorded on the streets of San Antonio. Texas. The questions were opened ended. According to Charmaz (2014), grounded theory includes systematic and flexible guidelines for the collecting and analyzing of qualitative data. Charmaz reported, "from

the start, careful word-by word, line-by-line or incident-with-incident moves you toward fulfilling two criteria for completing a grounded theory analysis: fit and relevance" (p. 133).

The interviews began by starting with a social conversation, as suggested by Rubin and Rubin (2005), to create a relaxing atmosphere that assisted in developing a rapport and enabling participants to feel comfortable prior to answering questions.

No organizational influence was involved. The participants did not have any personal conditions that affected the information telling nor analyzing of the stories told. Cooperation from participants was given of their own free will. All interviews were conducted outdoors on a curb; participants were offered a folding chair and all but one decided to sit on the curb with me.

Demographics

This study sample was made up of 12 homeless individuals with self-identified mental illnesses who resided in San Antonio, which is located in Central Texas in the United States. Participants were of African American, European American, Hispanic American, mixed, and Cuban and Middle Eastern descent; all ranged in age from 24-64 years. All participants had at least one mental illness. They reported a range of years of homelessness from months to years. Eleven participants reported no steady income, and only one participant was receiving SSI benefits; none were receiving social security. Participants reported some education, with two having quit formal school in the third grade, two others in the sixth grade. Six reported having graduated high school, and two had a year or 2 of college.

The participants were approached individually when I presented the reason for my research. There were several persons who appeared drunk or high, whom were not coherent; therefore, they were excluded as participants from this study. Participants included into my study were (a) 18 years or older, (b) chronically homeless, (c) had a mental illness. Participation was voluntary, and each participant was eager to be interviewed and audio recorded.

My research was intrinsically connected to my work experiences; for over 25 years, I have worked with individuals living with chronic mental illnesses from the state hospital, outpatient/inpatient psychiatric settings, and in private practice. Positive social change could be made in the way that agency funding is allocated for outreach programs by participants sharing their personal journeys, in their own words. The changes to these programs could transform the ways that people who are living on the streets in San Antonio, Texas are identified. I listened to the life stories of each participant, uncovering pain, ugliness, despair, happiness, loss of happiness, and what would make his or her lives easier while living on the streets. I was touched by each person who agreed to share his or her life circumstances in order to make positive social changes that could humanize and address stigma, which is a barrier the homeless who are living with mental illnesses on the streets of San Antonio, Texas face.

Tables 1 through 5 summarize the dates of birth, place of birth, ethnicity, education, and income level of participants. Data were collected throughout the interviews.

Table 1

Demographics of Year of Birth

Year of birth	# (*n*=12)	Percent
1954	1	2.70
1956	3	13.51
1986	2	5.41
1991	1	13.51
1992	2	13.51
1995	2	13.51
1996	1	16.22

Table 2

Demographics: Place of Birth

Place of birth	# (*n*=12)	Percent
Texas	4	48.65
New Jersey	1	5.41
Puerto Rico	4	5.41
Pennsylvania	1	2.70
Iraq	1	2.70
Not stated	1	2.70

Table 3

Demographics: Ethnicity

Ethnicity	# (*n*=12)	Percent
Black	2	29.73
Hispanic	4	21.62
Mixed	3	8.11
Caucasian	2	24.32
Irian	1	16.22

Table 4

Demographics: Education

Education	# (*n*=12)	Percent
Some high school	2	18.00
High school graduate	2	18.32
Trade school	4	45.00
Some college	2	18.22
College graduate	0	00.00
Graduate degree	0	00.00

Table 5

Demographics: Annual Income

Annual income	# (*n*=12)	Percent
$0-<$20,000	11	99.00
$20,000-<$40,000	1	1.00
$40,000-$65,000	0	00.00

Data Collection Process

Twelve participants were included in this study, and my assistant and I

approached individual participants and asked if they were homeless. If they answered in

the affirmative, then they were then asked if they had a mental illness. If participants met

the criteria, I reviewed the consent form and the reason for the research to the

participants. Fisher (2012) reported that potential participants who have disabilities

and/or those with mental health problems often expressed a desire to participate in

qualitative research, sharing how it is regrettable that their stories could be based on their

perceived vulnerability. Positive freedoms are identified as the right to having a voice,

which can be key in preventing attacks on human wellbeing (Arendt, 2004; Somers,

2008). Arendt (2004) shared that to be human is in the recognition by another and

reported that if speech is denied a person, he or she could be left vulnerable in system that

ignores human dignity and rights.

I requested that each participant agree to be audio-recorded, and I went over the

provisions in the informed consent form for each participant who was audio recorded.

The consent form explained the rights of the participants for confidentiality (Appendix

D). I then went over the compensation that they would receive for their participation. Each participant received $15 cash at the completion of the interview, but if he or she felt uncomfortable in any way and decided he or she no longer wanted to participate, he or she still received the $15 and a resources pamphlet that he or she could use for food, shelter, psychiatric/medical care, and shelters.

Purpose Statement

The purpose of the study was to explore how consumers navigated through different existing community resources for their medical, mentally ill care, and safe housing. The participants shared their personal perceptions and experiences in navigating through current psychiatric/medical care and safe housing programs and how the difficulties faced could be reconciled in the future. I chose a grounded theory approach for this study; interviewing, document analysis, and observation were used as a part of that process.

Evidence of Quality

Merriam (2002) shared that one of the goals of qualitative research is to provide an in-depth understanding of the experiences and perspectives as seen by participants in the study. According to Fassinger (2005), the qualitative method has gained acceptance in psychology and is known for its rigor. Neuman (2011) stated that "ethics begin and ends with you, the researcher" (p. 143).

Coding of Themes

Rubin and Rubin (2012) stated that data analysis is a way to look for patterns in order to explain phenomena under investigation. I used line-by-line coding, one of the

central tasks of grounded theory. Open coding is the process of selecting and naming categories from the analysis of the data. Strauss and Corrin (1999) reported that this is the primary level of acquiring and describing general features of the phenomenon under study. This process yields highly organized and usable datasets (Charmaz, 2014). Twelve transcripts were imported into NVivo11 for coding. Data coding and analysis was completed in order to answer the research questions. The thematic analysis consisted of open and axial coding.

The first review was a reading through the entire set of interview responses in order to develop preliminary coding categories that would answer the research questions. Open coding was conducted using line-by-line and sentence analysis. Primary, first-level categories were generated based on the research questions and from the answers given by the informants in the transcripts. This yielded eleven primary categories:

1. Community resources

2. Eating food

3. Judgement

4. Length of homelessness

5. Mental health treatment

6. Personal background

7. Physical heal

8. Place to sleep

9. Reason for homelessness

10. Safety

11. Survival, daily existence

Each transcript was read a second time, and the data were coded, generating 40 second-level and nine third-level codes. The coding process produced 60 codes in total. The coded data were reviewed and grouped according to similarities.

Axial coding was used to assign and link the categories and subcategories of codes according to their properties and dimensions. Data from each transcript were decontextualized to allow for the development of patterns and sequences in the data. Inductive and deductive thinking was used to draw causal relationships between the categories of coded data to explain the phenomena. Emergent patterns were identified from the data to explain the lived experiences of mentally ill, homeless people in central Texas and their opinion and attitudes towards navigating housing and psychological/medical care programs. Eight themes were developed in total.

Data Analysis

Themes coded for in the data included the following:

1.   Improving outcomes for community resources

2.   Problems with community resource services

3.   The prominence of mental illness and psychological issues

4.   Barriers (that make it difficult to receive mental health treatment and/or medical care and safe housing)

5.   Addictive behaviors

6.   Poor preventative health

7.   Homeless and helpless

8.   Low family contact and support

Accessing Health Care

Theme 1. The participants indicated a need for community resources and assistance with jobs/employment, medications, clothing, obtaining an ID, and to increase self-motivation.

Theme 2. Problems that were experienced by participants were a lack of understanding of homelessness by staff, lack of understanding of depression by staff, poor treatment by staff, and participants' lack of education in regard to community resources. Participants also indicated a lack of education about mental illnesses.

Theme 3. High occurrence of mental illness and psychological issues experienced by participants.

Theme 4. Barriers experienced by participants for improving their mental health included not taking medication, self-medicating with alcohol, not getting assistance from community resource centers, lack of education about mental illnesses, and lack of self-motivation.

Theme 5. Behaviors of participants that impacted their health and wellbeing.

Theme 6. Lack of going to the doctor and/or getting physicals by participants.

Theme 7. Participants' reasons for being homeless.

Theme 8. Little to no family contact and support received by participants.

Community Resources

Community resources available to participants to improve their quality of life; organizations that serve a particular area by providing tools to assist those in need to improve their quality of life.

Resources Accessed

Eleven participants made 51 references regarding resources accessed.

Resources Needed

Nine of the 12 respondents referenced resources needed and mentioned resources 19 times during their interviews. Nine respondents mentioned resources they needed 19 times.

Resources Not Accessed

Eating and/or food. four participants made references as to whether and/or how often they ate and/or obtained food.

Judgement. Two out of six participants stated that they felt judged by their circumstances.

Length of homelessness. Eleven of the participants made 13 references regarding the length of time that they remained homeless.

Reason for homelessness. Reasons for homelessness were described as due to abusive relationships, addiction, family, just gave-up, jail, kicked out of home, lost apartment, lost children, lost job.

Where participants slept. Eleven participants mentioned (26 times) where they slept while homeless or not

Mental health treatment. Eleven of the participants discussed their mental health situation and treatment, mentioning this topic 67 times. Respondents described histories of attempted suicides, bipolar diagnoses, anxiety, depression, schizophrenia, posttraumatic stress. They reported experiencing sadness, mood swings, and described attempted suicides. Ten respondents (83%) reported depression (mentioned 67 times).

Results

Each participant talked about problems accessing community resources that could improve their quality of life, as well as organizations that serve a particular area by providing tools to assist them in improving their quality of life. The lack of understanding of mental illness and homelessness often results in poor treatment by staff in these locations. Most participants believed that this was because there is a lack of education on both sides. Some participants shared how many people who are homeless just give up believing that they are worthy of change because they have been treated with disrespect and looked down on. They noted that they felt that this was because they wear dirty and soiled clothes and often smell of urine.

Participant 10

Participant 10 was a self-identified Black male. This young man openly shared his story, saying:

> In 2013 I became homeless I was going to career point college and I got a call from my sister in Jersey she told me my little niece had been sexually abused by her biological father… I kind of flashed back to when I was little like 6 or 7 when my cousin (male) I told my grandma and them, and they didn't believe me. It is

what it is. It's not good to say it like that. But either I come to a point being 40

right now, you either dwell on it, or as they say you buck up and keep it moving.

Because of this I learned to keep my business to myself… you don't tell no body

anything. I just gave up.

When asked if he ever talked to anyone about this, Participant 10 stated, "No I kept it to

myself but if anyone said anything I would just burst out in anger and violence because

it's all I knew that's all I know. You get over it at a point in time." When asked about

violence, he shared

Out here is just like kill or be killed, you know. It's just the way I look at it.

Because if you don't pay attention to your surroundings is just like being locked

behind a cage. I you don't pay attention to your surroundings something bad

could happen.

When asked what he thought could help him in accessing community resources,

Participant 10 replied, "Just getting up off my ass and going to get it." I asked if he was

talking about motivation and he said "Motivation".

And because at first, I was like everybody else, but I went to Wellness, and I sat

there and watched, and that place Haven for Hope a lot of people don't like it

because some of them are lazy. I'm not trying to put anyone down. Most of them

have addictions, so they're stuck to those addiction's and going through the same

circles and circles. So, where it's like, this is all I know, but it's not all you know,

you know. And they help if you want to help yourself. If you get to the point that

enough is enough. Addiction is a hell of a thing that some people don't know how

to climb out of. People give up on life because they've lost everything, their homes, families some just lost their way of living.

Participant 10 talked about other community resources and stated, "There are tons of resources around here from Haven for Hope, the Salvation Army, and Christian Assistant Ministry (CAM) to the Church under the Bridge." He said he had lost his ID and CAM helped him get another one; if needed he said, "CAM will help get your birth certificate or your Social Security card, or if you have to see a doctor they help pay for that." When asked if these resources available to most homeless persons, he said most people do not know about them, noting, "Nine out of ten people can prove that you need this and it's going to help you succeed nobody is going to turn you away."

Participant 10 shared that he remembers telling somebody before he became homeless that "he was the one that couldn't be homeless because he knew how to hustle… but when it happened." "Self-is everything. It's not being selfish, it's trying to figure out what yourself is all about." Participant 10 stated, "Well it is but procrastination is a mother fucker too." Participant 10 talked about being in prison for 2 years and 6 months, all drug related for using or selling. In 2015, he was diagnosed with posttraumatic stress disorder (PTSD) manic depressive with anxiety. For many years he was self- medicating, but he did not know that he was trying to stop the pain.

Participant 10 shared how he tells other people not to give up: "Abraham Lincoln having had 21 different jobs, and never gave up and became the president of the United States, or how Thomas Ford tried 21,000 times before he finally built a Ford and because he too never gave up."

When asked his opinion on how he sees access to community resources for safe housing, medical and psychiatric care, he said,

Like coming out here talking to people every day, basically. Some people just be out here so they be looking for food, and you see people riding by dropping off food and just not looking at homeless people bad because we're not bad people we just went through bad situations.

Participant 3

Participant 3 stated,

You see there are no bathrooms available for us and no way to clean up after taking a shit no showers or ways to clean clothes or clothes to change into there are only so many times one can be humiliated and realize you don't exist no one makes eye contact with you they just walk fast past you.

He expressed how he sees the issues of getting help for his mental illness and homelessness.

I've been in and out of psychiatric hospitals for years and homeless living on the streets and for some reason the situation on the streets is worse today than a few years ago. Doctors put me on numerous medications Haldol was one of the first that I can remember… Seroquel Prozac the list goes on… once I was let out there was no way to continue the medications.

Participant 12

Participant 12 was a Hispanic male who did have Medicaid and SSI at one time, but he lost both benefits because he had no way of receiving mail and he missed

appointments. Without benefits, he did not go back to the psychiatrist for 2 years. When asked why he did not go to community outreach programs to work at getting his benefits reinstated, he stated, "said he just got tired of running around and again missing appointments." He shared having auditory and visual hallucinations and off medications for over 1 year.

Participant 1

Participant 1 was a Hispanic male who shared being homeless between 8-10 years. He had a sixth-grade education; as a child his father would hit him and tell him to shut up and tell him he was stupid. He worked odd jobs most of his life. He shared having a problem with alcohol for many years. When asked how he became homeless he said, "I'm suffering from depression and by being depressed, suffering major depression… when you're depressed it's hard you know to keep a job or pay for a house." When asked where he stays, he said,

> Sometimes shelters, sometimes with a friend it all depends you know…I go to
> Haven for Hope one time I did stay long enough to be on the inside it is warm and
> dry, but they take you to the outside that's when I would get sick. When I stay on
> the streets I go under the bridge I don't feel safe I have to be friendly just to
> survive.

Participant 2

Participant 2 stated the following when asked how long he has been homeless:

> I've been homeless for six years I couldn't get alone with my family, my brothers
> and stuff. My mom passed away I do have family here but I'm like the black

sheep, you know. I stay over her by Guadalupe, by the bridge…by the Guadalupe

overpass thing...the bridge it goes up.

Participant 2 claimed he was safe staying under the bridge. He replied, "I'm okay...I do

fine." He shared that he has not seen a medical doctor in about 4 years but knows he has a

heart murmur. He shared being in prison. When asked if this hindered his chance of

getting a job, he replied, "what do you mean" I explained is it hard for you to get a job

because you went to prison." He stated he does day labor every day. He said he does

panhandle or he goes to churches when they offer food. When asked how he keeps clean

he responded, "I go over by the San Antonio River over there he said it is just like a

shower." When asked how he thought this research could make it easier for him to get the

help he needs, he stated, "I don't know...I know were not supposed to be standing around

here." When asked if he ever saw a dentist, he said no. His last statement was "I would

recommend nobody stay at the Haven for Hope." I asked why he does not recommend the

Have for Hope and he replied, "because there is always drugs in there."

Participant 11

Participant 11 self-identified as European American. She was asked what would

improve relationships with community resources and she said,

Communication is poor, and the challenges are many I am ashamed of my life and

have not been willing to truly want help or feel I deserved better… like I have

been an alcoholic for many years it almost killed me. I have been in very abusive

relationships had on boyfriend I met here (Texas) took me and my youngest

daughter to another state he got drunk and tried to kill me one night my little girl

cried out and he quit. My sister came and took my daughter back to Texas. I

finally decided to get help for real this time and came to Haven for Hope.

Participant 4

Participant 4 was a Hispanic American female who shared,

I was living on the streets by the time I was 11 years old. I was raped by a relative

and pregnant by age 12. Moved from one place to another by 14 I was smoking

marijuana and prostituting to make money to survive on. I started using heroin

when I was seventeen. When I was… I think 21 years old a trick picked me up

and while he was driving he started talking about how much he hates whores and

his mother was a whore that's why I have killed whores before and buried and

you are next…I jumped out of the car I know he was going fast…I was all beat up

they say I was unconscious for days and I remember being in the hospital for a

long time. At one time I was seeing a psychiatrist and on medications but

eventually went back to using heroin again.

Participant 5

Participant 5 self-identified herself as an African American woman and she was

reluctant to answer questions regarding how she used community resources.

I don't ask nobody for help only the good Lord he wakes me up in the morning. I

don't trust nobody. I don't need nobody but my daddy and my God. I do have a

son he is three years old he stays with my daddy. When I don't go to see my

daddy and son I pitch a tent. I don't like talking about my life story because I feel

that it is going to be broadcast and everything.

Participant 5 was the only one receiving benefits SSI. When she said she felt as if everything would be broadcast, I assured her that everything we talked about is confidential and went over the confidential part of the consent form.

I chose to present Participant's 5s interview because it represents how difficult it can be to gain trust with some homeless, mentally ill persons.

Participant 8

Participant 8 was a European American female born in Wyoming, but her family came to Texas when she was a child. She said, "I don't have nobody here." She said she had been homeless for about 8 years after she lost her children. The state took custody of her children because somebody she was with hurt them and she failed to protect the children. She stated that

> I stay anywhere I lay my head down, sometimes I do go to Have for Hope shelter, but that homeless shelter is crappy, so I don't stay at the shelter long enough to be able to see a doctor so if I don't do their services, there's no help out there.

When asked if it would be helpful if there were resources available without having to be in a shelter she replied, "yes absolutely I go to some churches for food and I go over here by the San Antonio River for like cleaning up, I fold my clothes and put them in a plastic bag. I have gone four days without eating when I can't find work or panhandle."

Participant 8 said she finished the 11th grade in high school, and then she left home 4 years after her mother's passing because everything changed. She had 10 brothers and sisters, and their father checked out after their mother died.

Participant 8 said that she does have contact with a sister who lives in Kirby but has no transportation to get there to see her. She was able to talk with her youngest brother by phone a few months ago when her sister gave her his number. Her brother is a welder by trade, and she said if he could he would help her, but he was not near San Antonio.

Participant 6

Participant 6 identified himself as Hispanic American. He shared it had been a couple of years since he saw a doctor for any medical or psychiatric care. "I had a physical they said I was okay. Mentally, they say I'm depressed my thoughts are related to death." When asked how he thought this research could help open more doors to get care he replied,

> Well, to me, if people want to help us they have to understand that people being depressed is like being shy… you know. You have to go there and get them and help them because they can't even help themselves, you know. Their mind they think they can do it, but it is so hard. I hear voices they get bad when I become depressed

Participant 6 shared that he was living under a bridge and at the Haven for Hope in the court yard. He shared how in the past he drank alcohol from morning to night and was drunk all the time; now he only drinks a couple of beers a night. As with several participants, he shared having a rough childhood with physical psychological and mental abuse at the hands of their fathers and/or mothers.

Participant 7

Participant 7 was born in Tehran and came to the United States when he was 23-years-old. When asked how he came to the United States he said, "A plane." Since 1978 he's been a permanent resident of Texas.

He said he has been homeless for 4 years after spending 7 months in prison. When he was released, he had nowhere to go. He shared being charged with attempting indecency with a minor and spent seven months in jail. The participant said that when he came out (of jail) he had nothing. He has been going to rehab for sex offenders for 4 years, learning to be a better person, noting,

> But it wasn't that we had sex, or I raped her or anything. It was something-I don't want to minimize it, but it wasn't big of a deal and it made it big of deal, and now I understand it's really big of a deal because of what it does to a person. I was a painter I had my own painting company I used to work for a stain company. And then after I came out of jail, I opened up my own tree trimming business, and one of my workers stole all my tools and my truck. And I ended up with nothing again, that's why I'm back at the Haven.

The participant said that he did take medication while incarcerated for depression. He shared feeling sad and he did go to Haven for Hope but because of his offense it is almost impossible to get housing. He knows at the Haven for Hope they can find a place for offenders; he could apply but he just has not because he is lazy, saying,

> I stay at the Haven… on the streets right there at the picnic truck you stop by and they give out food…they come in the morning about four or five times and they

feed people. You know it's my mistake. It's payback and I'm paying back and it

is what it is till the next five years till I get back to my normal life… hopefully

things going to change for the best.

The participant said if he is ill, he can be seen at the clinic at Haven for Hope, or if he is

depressed can see a psychiatrist, he does not ask for help.

Participant 9

Participant 9 said he has been homeless for about a 1 ½ years. Before became

homeless, he lived off 24th Street and Commerce with a friend. They started to blame him

for things everything that went wrong. When asked if he used illegal drugs, he said the

only thing he does is smoke cigarettes. When asked where he sleeps, he said he stays in

an "abandoned place, anywhere safe and without noise."

Actually I've tried the Salvation Army right here. That's a pretty good place

there, I stayed there a couple of times, you know. Like sometimes I don't feel

safe, I'll go stay there because there I feel safe. He has stayed at the Haven for

Hope on the outside in the court yard. There are times when I feel safe,

sometimes I don't...but it's a chance you're taking, I mean, and the risk.

Participants gave many reasons for being homeless and believed their situation is

hopeless. One barrier was the lack of access to mental health medical care or safe

housing; communication was identified as often missing, which is paramount in bridging

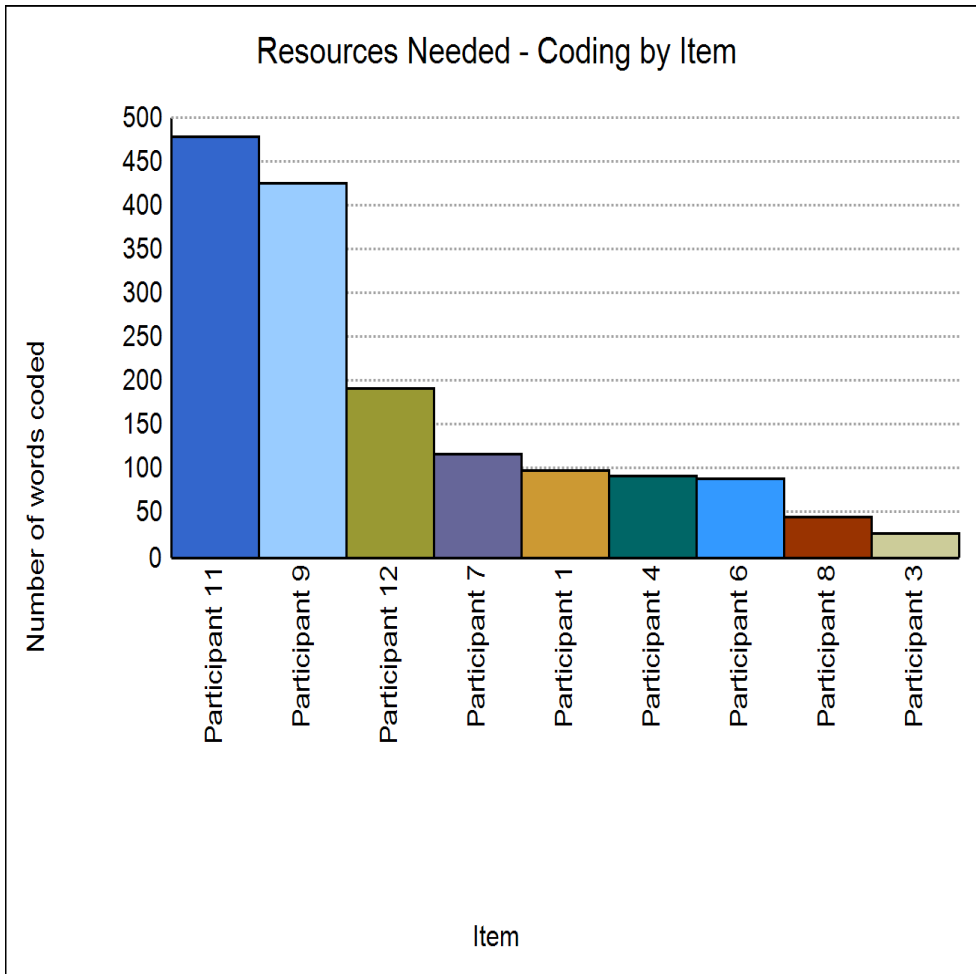the gaps in successful outreach programs. Figures 1-7 show the results of the study.
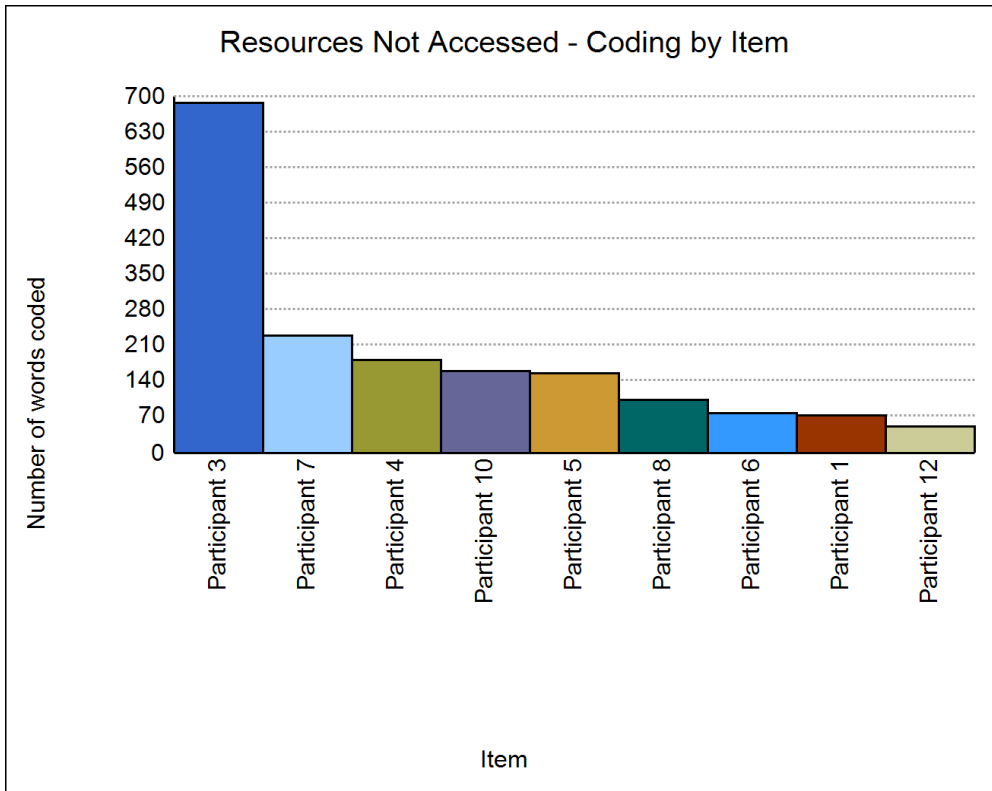
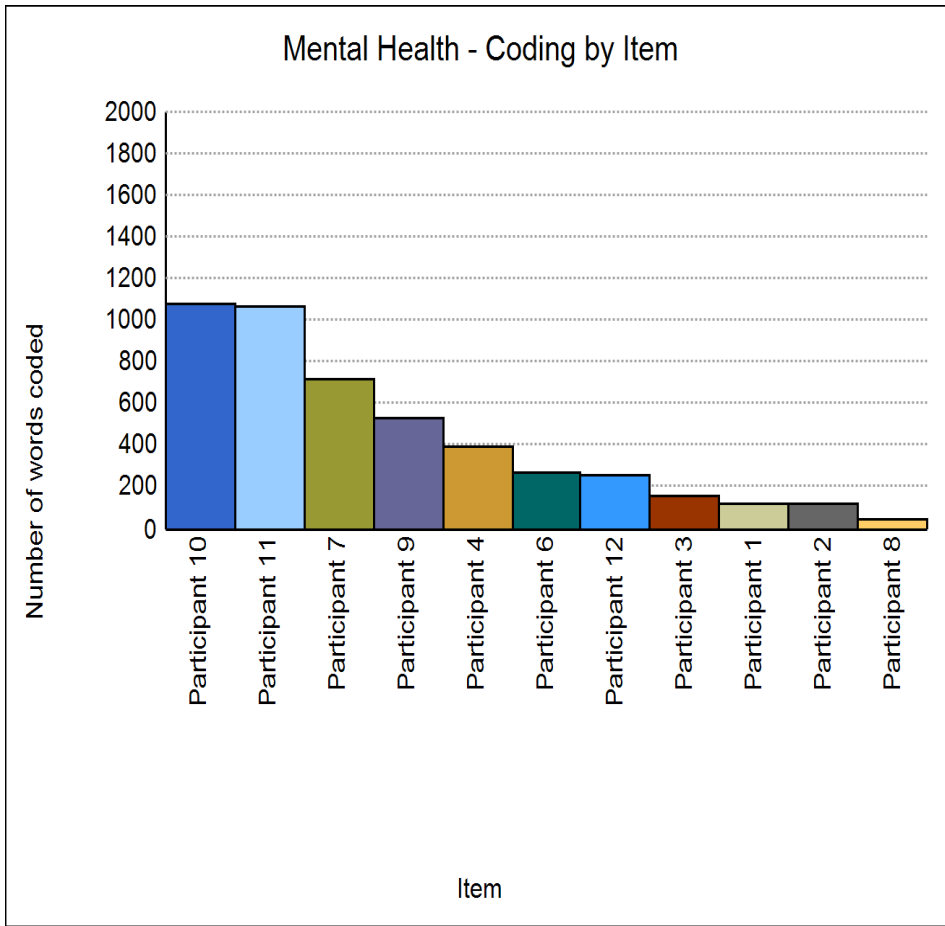*Figure 1.* Resources needed.

Figure 2. Resources not accessed.
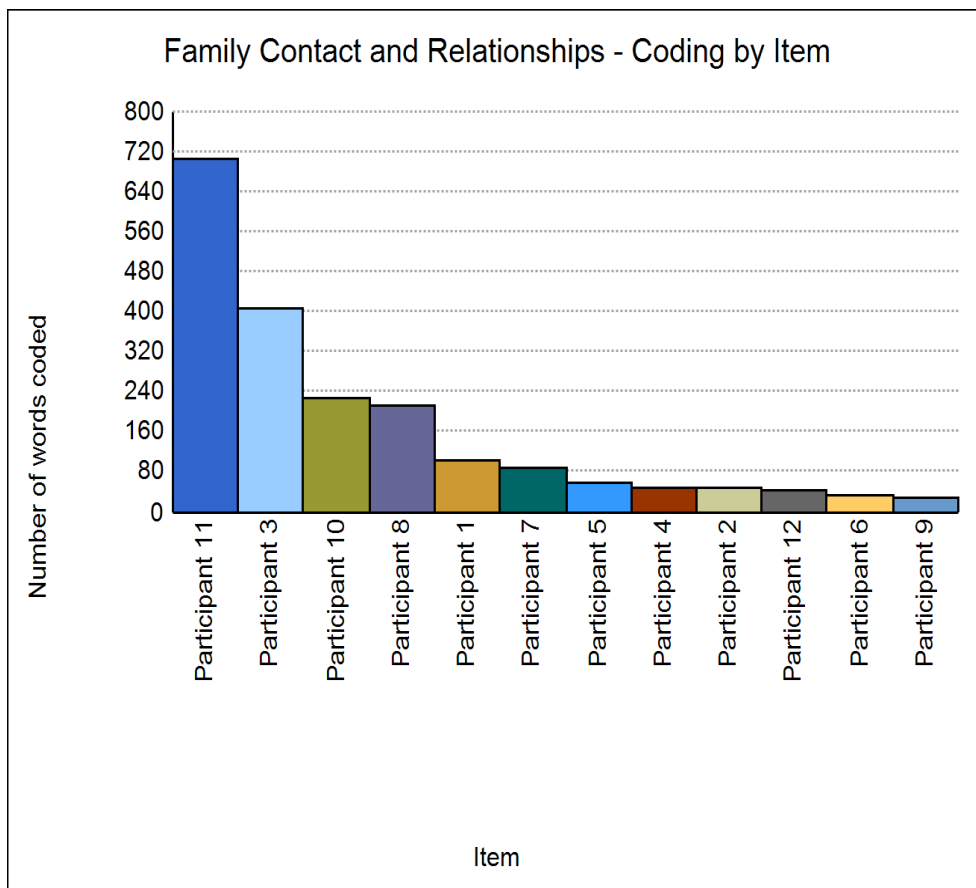
Figure 3. Mental health by coding.

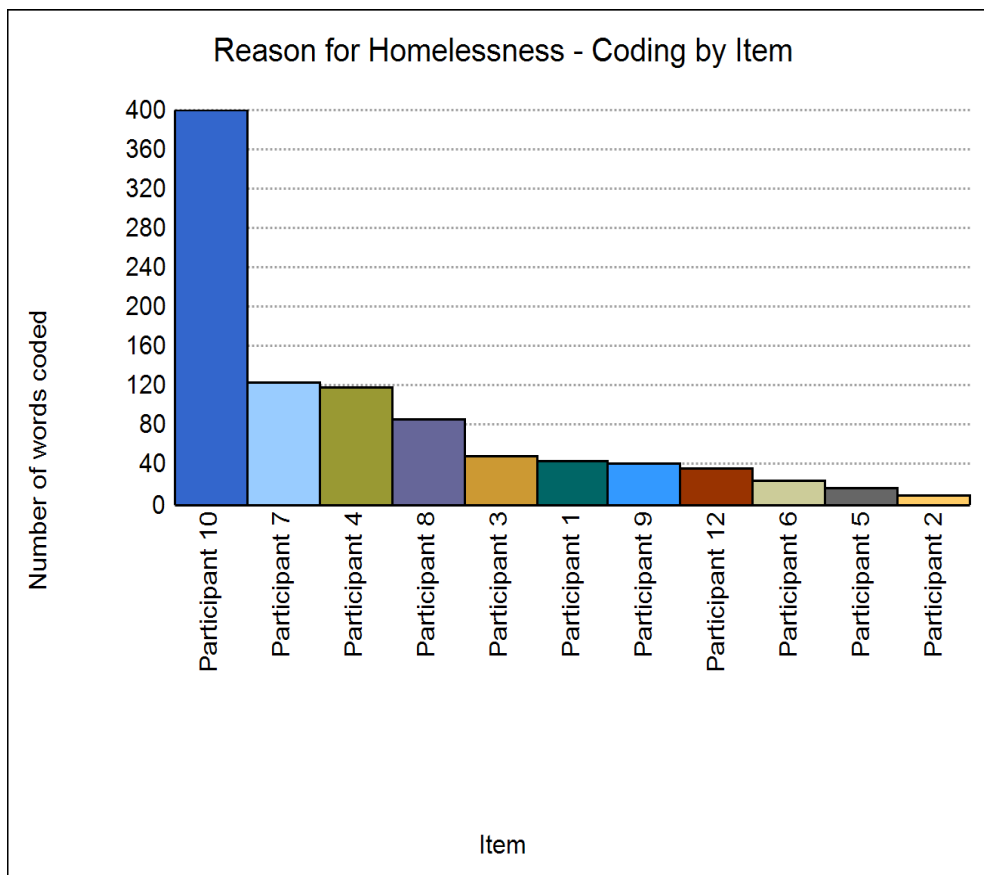*Figure 4*. Family contact and relationships.
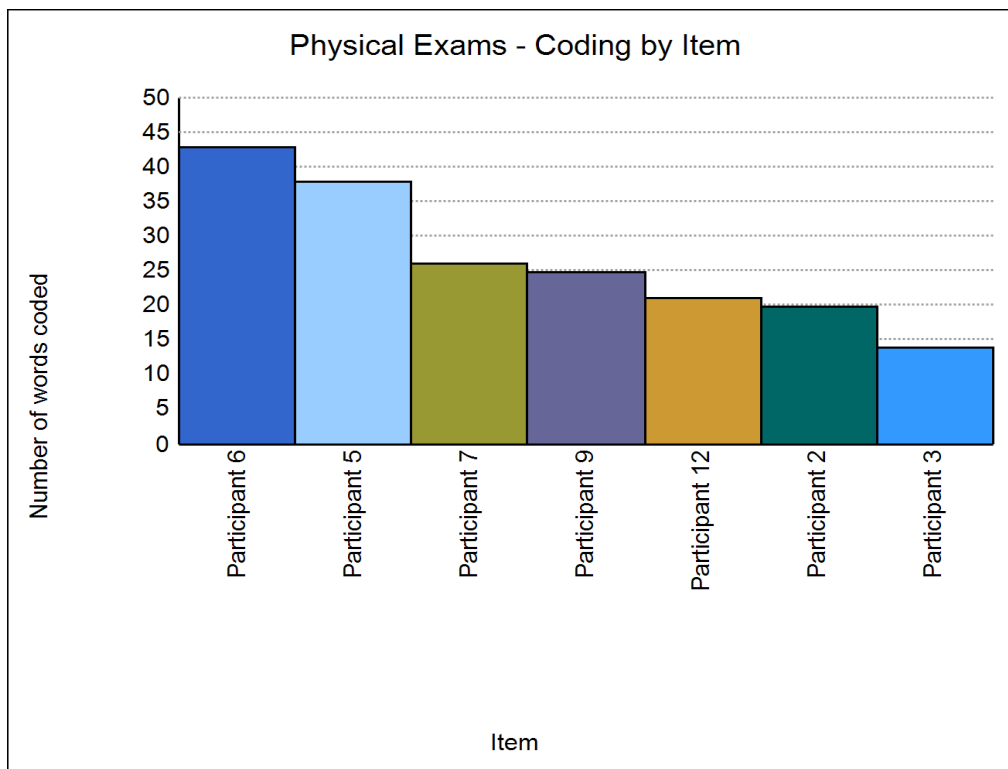
Figure 5. Reasons for homeless.
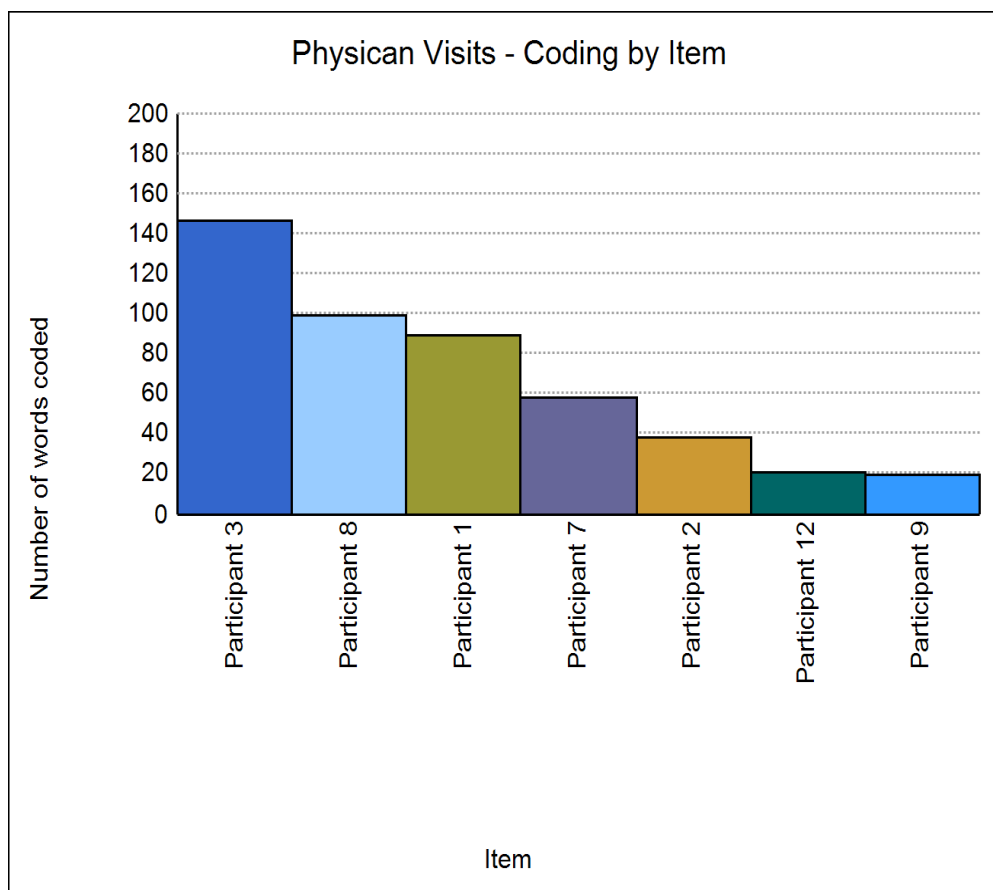
Figure 6. Physical exams.

Figure 7. Physician visits.

Researcher Bias

I remained neutral throughout the interviews, putting all biases aside to ensure a nonjudgmental attitude. This outlook helped my participants achieve a level of comfort throughout the interview. I did keep all my personal opinions, experiences, and prejudices dormant, which eliminated any negative influence in the study. I am aware that this topic is controversial; therefore, I am aware of my biases and remained comfortable when conducting my research.

Concerns of Trustworthiness

After approval from the Walden University IRB, and in accordance to the ethical guidelines of the APA, all ethical procedures were maintained for all participants. Informed consent introduced the contact information, the research process, the intent of the study, and the voluntary participation by participants. Participants were informed of their rights to privacy and confidentiality and how their information will be used.

Evidence of Trustworthiness

When working with a vulnerable population, it is necessary to use an ethical practice model. Researchers achieve credibility when they design their study in a way that demonstrates believability to the participant in the study. While working with a vulnerable population, my goal was to ensure each participant understood the nature and extent of their participation. My personal experience working with persons diagnosed with bipolar, schizophrenia disorder while working as a case manager afforded me the opportunity to work directly in their lives. Therefore, gaining trust was paramount to successful engagement with individuals diagnosed with chronic mental illness.

During the interviews, if something a participant was conveying was not clear, the participant was asked to repeat what he or she said, letting the participant it was important that his or her voice be clearly heard. Qualitative research was used in this study because the goal was to garner an understanding of a paradigm where little has been established regarding the problem or variability prior to my study. Flick. U. (2007) qualitative research elicits an understanding of the phenomenon by generating meanings shared by participants' experience, feelings, and perceptions.

Findings

The purpose of this research was to explore the experiences and opinions of homeless participants with mental illness and of the barriers they face. Data were coded; this process produced 60 codes in total. Eleven made 51 references regarding resources 19 times during their interviews. Nine of the 12 respondents mentioned resources they needed 19 times. Participant 3 shared the need for bathrooms because there are no bathrooms available for "us" "and no way to clean up.

Summary

My goal was to investigate how homeless mentally challenged individuals see their future in accessing mental/physical care and safe housing. I interviewed 12 participants. After they were asked if they were homeless and had a mental illness and if they were 21 years of age or older, they were given a consent form (Appendix A). I sat with them and read the consent form, making sure they understood what they were consenting to and made sure they knew at any time if they felt uncomfortable, they could end the interview and they would still receive their $15 and brochure. After this process was completed and each participant verbalized, they understood the consent form, the interviews began. Each participant shared in their own words the reasons for being homelessness and how they viewed their access to community services to include safe housing.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to allow homeless, mentally ill, adult participants to share their experiences concerning access to care and the obstacles they face as they seek shelter, psychiatric care, and medical treatment. Twelve individuals were interviewed about their personal experiences with mental illness, homelessness, and access to shelter services. A qualitative approach was chosen for this study in order to allow stakeholders to share their real-life experiences in their own words and to allow for more detailed information to be gathered from participants in a more holistic and flexible manner that avoids prejudgment. Listening to the voices of persons living on the streets, especially those who are mentally ill, is paramount in making positive societal change. Future research addressing firsthand information could be valuable for community outreach services as they combat the negative consequences of the deinstitutionalization movement that began in the 1950s and has plagued the mental healthcare systems ever since. In this chapter, I present a discussion of the insights provided by 12 individuals who have personally experienced homelessness and mental illness.

Summary of Emerging Themes

After conducting 12 interviews with mentally ill, homeless adults, the most common theme that emerged concerned the participants' self-awareness of their poor hygiene, resulting in smelling of urine, and how this contributes to the stigma of being homeless and their shared feelings of shame and defeat. This stigma often resulted in a lack of motivation by the participants to reach out to whatever community resources

might be available. There is a stigma that the homeless choose to be homeless,

specifically when the participants shared a commonality of circumstances that caused

their situation. In addition, themes such as loss of income, drug addiction, mental illness

specifically post-traumatic stress disorder, schizophrenia, major depressive disorder, and

history of sexual abuse emerged as concerns.

Theme 1

There is a need for community resources to promote assistance with employment,

medication, clothing, obtaining legal identification, and self-motivation.

Theme 2

There is a lack of understanding by staff at various community centers of the

homelessness experience, depression, and generally poor treatment by staff. In addition,

many adults who are homeless and mentally ill lack information about community

resources and how to access them.

Theme 3

A participant stated, "I'm suffering from depression and by being depressed,

suffering major depression… when you're depressed it's hard you know to keep a job or

pay for a house." Another participant reported being in and out of psychiatric hospitals

for years and homeless living on the streets. "Doctors put me on numerous medications

Haldol was one of the first that I can remember… Seroquel, Prozac the list goes on…

once I was let out there was no way to continue the medications". Eleven of the

participants discussed their mental health situation and treatment, mentioning this topic

67 times. The respondents described histories of attempted suicides, bipolar diagnoses,

anxiety, depression, schizophrenia, and posttraumatic stress. They reported experiencing sadness, mood swings, and described attempted suicides. Ten respondents (83%) reported depression (mentioned 67 times).

Theme 4

The participants reported issues around their mental health that included not taking medication, self-medicating with alcohol, not getting assistance from community resource centers, lack of education about mental illness, and motivation. For example, one Hispanic American male did have Medicaid and SSI at one time, but he lost both benefits because he had no way of receiving mail and he missed appointments. Without benefits he did not go back to the psychiatrist for approximately 2 years. When asked why he did not go to community outreach programs to work at getting his benefits reinstated he stated he "just got tired of running around and again missing appointments." He also shared about having auditory and visual hallucinations and being off of his medications for over 1 year.

Theme 5

The participants shared experiencing the stigma of mental illness and homelessness that permeated virtually all aspects of their lives.

Theme 6

The participants reported a lack of consistency in going to the doctor and getting routine physicals and health care. One recurring issue involved the lack of regular transportation to appointments and is an area that could easily be addressed.

Theme 7

The participants shared numerous reasons for being homeless. Eleven of the

participants discussed their mental health situation and treatment, mentioning this topic

67 times. The respondents also described histories of attempted suicides, bipolar

diagnoses, anxiety, depression, schizophrenia, and posttraumatic stress. They reported

experiencing sadness, mood swings, and described attempted suicides. Ten respondents

(83%) reported depression (mentioned 67 times). Several participants shared histories of

abuse, sexual, physical, and emotional. One participant said she was living on the streets

by the time she was 11-years-old, and she was raped by a relative and pregnant by age

12. After that she moved from one place to another, and by 14, she was smoking

marijuana and prostituting to make money to survive. She said she started using heroin at

age 17. One male participant shared being homeless between 8-10 years he has a sixth-

grade education. As a child, his father would hit him and tell him to shut up and tell him

he was stupid. Several participants shared how people give up life because they were too

tired to fight the battle.

Theme 8

Participants shared having little to no family contact or support.

Discussion of Emerging Themes

Leff (2001) recommended advocacy by mental health professional to explain the

system and its positive impacts; Leff encouraged mental health professionals to promote

greater integration of patients into society and workplaces. Boardman (2006) stated that

adults with SPMI who are often homeless have experiences limited access to health care, which resulted in higher mortality rates.

McCrea and Spravka (2008) examined the opinions of severely mentally ill homeless consumers regarding housing and psychological services. McCrea and Spravka stated that consumers would reverse the dehumanization of this group and provide insight into residential care alternatives and follow-up services. One obstacle identified was how to preserve the natural opinions of consumers without stereotyping them (McCrea & Spravka, 2008). In my study, listening to the voices of the participants and reporting their words bridged the obstacle preserving natural opinions of participants.

Recommendations

Listening to the voices of the 12 individuals offered me a glimpsed into what is lacking in addressing identified needs. Paramount to positive societal change is to provide for their immediate needs (ie., providing mobile access to bathrooms, showers equipped with shampoo, soap, toothbrushes, and clean clothes to include new underwear, having a medical unit to address the immediate needs of the homeless, and having a mobile unit where a psychiatrist is available to work with the mentally ill homeless).

It is important that mental health workers who choose to work with this population know that they will never know the sense of loneliness hopelessness expressed by my participants. In order to make positive social change, mental health professionals must acknowledge that each person has a story. Ignoring this ongoing issue in San Antonio Texas and throughout the United States will continue to exacerbate the struggle of future interventions.

Limitations of this Study

There were a small number of participants (12), and the location of interviews was limited to a downtown area of San Antonio, Texas. With a vulnerable population it is necessary to use an ethical practice model (Fisher, 2008). I respected the dignity and worth of my participants (APA, 2002) ensuring that each participant understood the extent of his or her participation. My personal experience working with persons diagnosed with bipolar, schizophrenia disorder while working as a case manager afforded me the opportunity to work directly in their lives, and this was paramount to the successful engagement with my participants. This method elicits an understanding of the phenomenon, generating meanings shared by participants experience, feelings, and the perceptions of the participant.

Conclusion

My personal experiences in working with people who have been diagnosed with bipolar schizophrenia disorder began while I was working as a case manager. This afforded me the opportunity to work directly in clients' lives. Therefore, gaining trust was paramount to having successful engagements with individuals. It has been a first-hand journey in the lives of the homeless participants diagnosed with chronic mental illness.

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Appendix C