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A

The Mentally Ill Homeless:

A Grounded Theory Approach to Understanding The Dynamics of Client Outcomes In a Therapeutic Residential Program

By

Peter D. Beitchman

A Dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York

2000

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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

January 27, 2000
Date

Chair of Examining Committee
Dr. Michael Fabricant

January 27, 2000
Date

Executive Officer
Dr. Mikahel Fabricant

Dr. Andrea Savage

Dr. Mildred Mailick

Dr. Harold Weissman
Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

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Abstract

The Mentally Ill Homeless: A Grounded Theory Approach to Understanding The Dynamics of Client Outcomes in a Therapeutic Residential Program

by

Peter D. Beitchman

Adviser: Dr. Michael Fabricant

Large-scale homelessness seemed to burst upon the American urban landscape in full force in the early 1980s. This dissertation tracks the broad arch of response to the homeless in general and the mentally ill homeless specifically.

First, it presents a critical review of the literature developed to understand the causes of homelessness and characteristics of the homeless. This review contrasts the findings of the quantitative and qualitative research conducted in the 1980s and their differing policy implications.

Next, the dissertation focuses more directly on the efforts to address the needs of the mentally ill homeless. Using a reputational method, a study was designed to identify and describe "excellent" programs. The three selected programs are analyzed using a framework developed by the author that seeks to identify the major structural elements of social programs. The comparative analysis of the programs highlights salient differences in programs for the mentally ill homeless.

The dissertation then offers an in-depth study of a selected program for the mentally ill homeless. The study focused on understanding client outcomes in a residential treatment program. Outcomes included "negative" discharge, "positive" discharge or "continued stay." The study used a combination of inductive, qualitative methods with the application of a

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deductive concept, "social worth," from the social work literature. All client outcomes that occurred over a six-year period were subject of the study.

The study yielded grounded theory that confirmed the existence of a "social worth" hierarchy as assigned by staff to clients in the program. It illuminated the "negative" and "positive" discharge processes, both in terms of the traits of clients discharged in these two categories and the norms of staff and client participation in these processes. It also identified a number of client roles valued by staff that conferred "continued stay" status on some clients. An essential finding was that the process through which staff "sorted" clients into the three outcome categories was largely unconscious and at times was at odds with the primary goal of the program: preparing clients for less supervised living.

The policy, programmatic and research implications of the findings are discussed extensively.

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Acknowledgments

In 1985, after a 17-year career in human services without the benefit of formal academic preparation, I embarked on an adventure that has enriched me beyond all expectations. It was then that I began the MSW program at Hunter College School of Social Work, leading to the doctoral studies that this dissertation now completes.

The debts that I owe to those who supported and inspired this journey are many; several stand out. First, to Murray Itzkowitz who understood my desire in 1984 to "retool" myself from the world of human service policy in which I had been working to the world of agency practice and management which I had a great desire to explore. Murray not only recruited me for the position that has become the singular passion of my career, he also encouraged my academic studies and even led the way through the doctoral program, showing me that "it could be done," despite demanding agency responsibilities and professional and family obligations.

Secondly, I owe an inestimable debt of thanks to the faculty of Hunter College School of Social Work, not just for sharing their knowledge but also for sharing their passion. They are an awe-inspiring group. Here I must single out Dean-Emeritus Harold Lewis, whose seminar course in the doctoral program continues to enrich my thought and insight into our professional endeavors. Next, Doctoral Program Executive Officer Harold Weissman, who not only imparted much wisdom but who also, along with Roselle Kurland, introduced me to the world of teaching at Hunter and who recommended me for the much appreciated financial support of my dissertation research. Finally, a special thanks to Michael Fabricant, chair of my dissertation

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committee and my shining exemplar of a seeker of knowledge in the cause of what is right.

I am also grateful to the many staff and clients who participated in the study and to the respondents in Chapter 2. Without their generosity in spending so many hours with me I could not have completed the task. Thanks also to: Dr. Harvey Catchen of the State University of New York at Old Westbury and his students with whom I worked on the design and collection of the quantitative data reviewed in Chapter 5; Dan Del Bene who helped analyze the quantitative data; and Karen Falcier for superb editorial assistance over many years.

My family -- Ginny, Amanda and Molly -- has tolerated this 15-year odyssey, not just with forbearance and extraordinary understanding, but also with support and encouragement that I often did not deserve. I gratefully dedicate this work to them and to my parents.

Finally, I would like to pay tribute to my social work colleagues who labor everywhere in a common endeavor to enhance the lives of those we serve. Your work and commitment have inspired me and I hope that this dissertation will in some small measure inform and enrich your practice.

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INTRODUCTION

The crisis of homelessness and the mentally ill among the homeless is now more than a dozen years old. The public policy debate about homelessness, and the programmatic responses that have followed in its wake, represent a case study of how serious social problems are typically addressed in the United States. To the casual observer there appears to have been an inexorably logical process at work in the response to homelessness. The earliest efforts in the process focused on gaining knowledge about the homeless: who were they, what were their characteristics and needs? Many studies sought to provide the basic information needed to inform debate through which a responsive public policy could develop. The next step in the process, then, would be to design programs that would, at a minimum, ameliorate the conditions of homelessness and, if possible, address its root causes.

As we shall see, however, there has not been a consensus about the characteristics or causes of homelessness. In the absence of consensus, and with a conservative national administration in Washington during the 1980s, no strong national policy took shape. (An alternative conception is offered by Bachrach and Barratz [1970] who view such "non-policies" as the result of a "mobilization of bias" that narrows or limits the policy agenda based upon the value preferences of those "in power".) Instead, program development around the issue of homelessness was assumed by state and local governments responding in a "crisis" atmosphere.

At the program level, something of the same process was repeated. A variety of programs were developed, each based on a particular view of the homeless and how to

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help them. These program efforts have now been in operation for more than ten years and, although formal evaluation studies are still sparse, it is imperative, from the perspective of gauging the effectiveness and cost-effectiveness of efforts to date, that program evaluation now take center stage.

This dissertation project is concerned with all three aspects of the response to the marked increase in homelessness that was first observed in the early 1980s. First, we are concerned with the processes and conclusions that were reached in the early efforts to understand who the homeless are, their needs and the causes of homelessness. The debate that developed in answering these questions will be explored in detail to highlight important issues in the ways in which research is conducted to develop basic knowledge about social problems.

Since the range of programmatic responses that followed was also shaped strongly by the research debate, a second area of concern of this dissertation is to analyze programs within the context of social work theory and practice. A framework will be offered that attempts to distill the underlying elements of social work thought in developing programs for the homeless and the mentally ill among them.

Next, a specific program developed to respond to the mentally ill homeless will be analyzed and evaluated. The focus of the evaluation will be on the outcomes of the clients who have been in the program. The theoretical underpinnings of the proposed outcome research will be explored. By studying client outcomes in the program under study, and illuminating the dynamics and process that affect them, we hope to gain

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insights that will suggest improvements to help programs that serve the mentally ill homeless succeed in permanently interrupting the cycle of homelessness.

Throughout, we are concerned with the single homeless who are designated as mentally ill. A similar approach could be used to explore the policy-generation and programmatic responses to other sub-groups of the homeless (families, youth, mothers and children, etc.). At its most general level, this dissertation project is concerned with how a social problem is identified, understood and addressed. When "addressed" is specifically translated into "program," we are concerned with how social work and social workers are involved in the conceptualization, design and operation of social programs.

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CHAPTER 1

Understanding the Problem of Homelessness

Introduction:

Large-scale homelessness seemed to burst upon the American consciousness all at once and with full force during the early 1980s. During this time, such diverse urban centers as New York City, Los Angeles, Boston, Detroit, Philadelphia, Minneapolis, Detroit, Milwaukee, St. Louis, Pittsburgh and Baltimore reported large numbers of homeless men and women, disaffiliated and often found in places other than former "skid rows," including transportation terminals, parks, other public places and, literally, the streets (Arce, et. al 1983; Bassuk et al, 1984; Fischer et. al, 1986; Koegel et al, 1986; Breakey et. al, 1988; Davies et al, 1987; Kroll et al, 1986; Gellberg et al. 1988; Mowbray et al, 1986; Rosnow et al, 1985; Roth and Bean, 1986; Mulkern, 1985; Crystal et al, 1986).

Although it seemed the problem was recognized everywhere, controversy beset every aspect of gauging, understanding and responding to it. Even the number of homeless was the subject of serious debate, with estimates ranging from 225,000 to 3 million nationally (Kondratas, 1991). Beyond numbers, the causes of homelessness were disputed continually -- economic and sociocultural factors versus failed mental health policy -- (Toro Trickett, et al, 1991), clouding the development of effective public policy responses.

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Three major social changes occurred in the U.S. during the 1960s and 70s. each of which was identified as the major "cause" of homelessness: (1) the loss of more than one million units of inexpensive housing due to demolition or conversion to middle- or upper-income housing and the virtual suspension in the development of new federally subsidized low income housing; (2) the loss of millions of manufacturing jobs in the shift to a service economy and resultant dislocation and "structural unemployment" of low income workers; and (3) the discharge of more than two-thirds of the nation's 700,000 state psychiatric patients into the community without provision for adequate housing (Toro, Trickett, et al, 1991).

For the public and policy maker, the definition or "framing" of a problem (Rein and Schon, 1977) shapes and specifies potential solutions. Hence, while the need for clear definition is paramount, in the area of homelessness, a lack of consensus yielded conflicting theories, research findings and policy prescriptions.

The examination of the relationship between homelessness and mental illness was central in the attempt to define homelessness and develop responsive programs. During the 1980s, a considerable amount of research was conducted to determine the number of mentally ill among the homeless, their characteristics and service needs. The often contradictory findings within this body of research engendered a debate that shed light not only on the subject of homelessness, but also on the methodological problems that arise in the study of social phenomena.

This chapter will first survey the major epidemiological research on the mentally ill homeless during the past decade. Epidemiological studies are aimed at documenting

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the extent of a selected condition or phenomenon in a defined population (i.e., a particular disease, social condition, etc.) and identifying the factors that contribute to the creation of the condition. The study of homelessness represents an excellent example of the application of epidemiology to a social problem. As we shall see, both quantitative and qualitative methods were used to capture the epidemiological dimensions of homelessness.

The review will then offer a methodological critique of the epidemiological research developed from within the quantitative paradigm, as well as the parallel body of qualitative literature that also developed. In this context, the major findings of the qualitative literature will also be reviewed. We shall be concerned, then, with both our substantive knowledge of the homeless and the methods used to study them.

Preliminary Methodological Discussion

During the 1980s, two major methodological approaches were used to conduct research on the homeless: quantitative methods (primarily cross-sectional, survey research) and qualitative methods (ethnography). The quantitative approach, the method through which epidemiological studies are usually conducted, offers several potential advantages. Through the rigors of scientific and statistical methods (i.e., standardization and operationalization of terms, concern for internal and external validity and reliability, specification of method and use of standardized instruments and methods of data analysis), the quantitative method offers the possibility of generalizing findings beyond the study sample. In this way, theories can be tested, knowledge can be accumulated and concomitant policy recommendations can be generated. As we shall see, however, the

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use of quantitative methods to study the homeless entails a number of logical and methodological problems.

The most commonly employed alternative method used to study the homeless was ethnography. In utilizing this qualitative method, the research tries to render "true to life a picture of what people say and how they act" and to portray "how people go about the task of seeing, describing and explaining order in the world in which they live" (Taylor and Bogden, 1984, p. 11).

Concerned with meaning as ascribed by the subject and inductive by nature (concepts, insights and patterns are derived from the documentation of the subject's "reality"), ethnography seeks to "know" subjects "holistically" in their natural settings and over time through "unobtrusive" participant observation (Taylor and Bogden, 1984, pp. 8-10). Ethnography yields what Geertz (1973) calls "the thick description of social life." By entering into the world of their subjects, ethnographers seek to describe their subject's reality fully, based on first-hand knowledge. While this method has obvious virtues, its limitations include the difficulties in generalizing beyond the subjects of study and a "conservative bias" toward viewing the subject's adaptations as an idealized or preferred state.

The Accumulation of Quantitative Research on the Homeless

There is general agreement that Baxter and Hopper's landmark study Private Lives/Public Spaces (1981) galvanized public and professional interest in the homeless. Prior to its publication, through the 1970s, studies of the homeless centered on "skid row," the self-contained enclave of alcoholics found in most large American cities

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(Vergare and Arce, 1986). Baxter and Hopper reached beyond "skid row" to a variety of settings (shelters, streets, parks, transportation depots) and using the qualitative methods summarized above, described the often harrowing day-to-day lives of the homeless. Among their conclusions, reaffirmed in a follow-up study (Baxter and Hopper, 1982), was the suggestion that a significant portion of the homeless they observed appeared to be suffering from psychological stress.

In the early 1980s, quantitative researchers in many cities initiated studies to learn about the homeless, and the relationship between homelessness and mental illness in particular. Most of these were epidemiological studies designed first to determine the extent of mental illness and second to assess the characteristics and needs of the mentally ill homeless. In addition to locally and state-sponsored research, between 1982 and 1986 the National Institute of Mental Health (NIMH) supported nine epidemiological studies (eight single-city studies and one statewide). Kroll et al (1986) discussed the epidemiological focus of the 1980s. With sharp public dispute surrounding the issue of "blame" for homelessness and with a need to define the problem in a way that would suggest meaningful solutions, Kroll asserted that "coherent social and medical policy toward the homeless must begin with some basic knowledge of the characteristics of homeless individuals" (p.283).

An early effort to begin to develop such knowledge was a study conducted in Boston by Bassuk and associates (1984). The method employed became familiar in many later studies: during a selected week, all residents of a shelter were interviewed by mental health professionals (psychiatrists, psychologists, social workers) who determined

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mental illness based on the criteria of the American Psychiatric Association's Diagnostic and Statistical Manual. Third Edition (DSM III). During the interviews. basic demographic data and information on the pattern of homelessness. medical problems. involvement in the criminal justice system. history of psychiatric hospitalizations. family and social relationships and employment and income were also collected. All data were gathered through self-report of the subjects.

Bassuk et. al. (1984) reported that of the 78 subjects. eight were "too severely mentally ill to answer the majority of questions" (p. 1546). However. they were included in the study. The major finding of the study was that 91 percent of the shelter users were diagnosed with "serious emotional difficulties," including 46 percent with major mental illness (schizophrenia, affective disorders or diagnosis of psychosis with alcoholism). 24 percent with alcoholism and 21 percent with serious personality or character disorders. These findings suggested strongly that homelessness and mental illness were indeed virtually synonymous. (The 9 percent of shelter residents who were given no diagnosis included children of parents in the shelter and a few "new arrivals" who expected to be working and relocated within a few days.)

Early studies in two other cities seemed to confirm the Boston findings. In Philadelphia. Arce et al (1983) also used DSM III criteria to diagnose mental illness in 84.4 percent of those in a public shelter and in Los Angeles, a "skid row" study found 75 percent of males and 90 percent of females using selected flop houses had an "incapacitating mental illness" (Farr. 1982).

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In 1984, the American Psychiatric Association (APA) included these findings and others in its first systematic response to the problem of the mentally ill homeless (Lamb, 1984). Organized under the rubric of a report of APA's Task Force on the Homeless Mentally Ill, the collection included articles that reviewed the literature to date, traced the history of deinstitutionalization and its purported impact on swelling the ranks of the homeless and outlined the service needs of the homeless mentally ill (e.g., psychiatric services, housing, rehabilitation, medical and legal services).

Taken in its entirety, the collection strongly supported the view that the homeless mentally ill are a subgroup of chronic psychiatric patients, the victims of deinstitutionalization. Their problems were framed within the overall context and history of mental health policy (particularly the failures of the era of "deinstitutionalization" (addressed also by Bassuk and Gerson, 1985; Bell, 1989; Foel and Sharfstein, 1983; Gruenberg, 1982; Levine, 1981; Morrissey, Goldman and Klerman, 1985; Wagenfeld and Jacobs, 1982). The need to create a comprehensive support system for the chronic mentally ill at the community level was stressed.

Bachrach's (1984) article in the APA report clearly articulated the need for further conceptualization and research to define homelessness, establish criteria of psychopathology among them and appreciate their diversity. She also highlighted the need to recognize the special characteristics of the homeless that challenge service providers (i.e., the perceived gap between provider and recipient expectations).

The report's 14 recommendations read very much like those developed a decade earlier in APA's call for comprehensive community-based services for the

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deinstitutionalized chronic mentally ill. The lacks of differentiation between the homeless and chronic mentally ill is not surprising, given the state of knowledge and dialogue at the time.

Between 1984 and 1989, more than a dozen additional epidemiological studies of the homeless were published (Arce, Tadlock et al 1983; Bassuk et al, 1984; Fischer, Shapiro et al, 1986; Koegel et al, 1986; Breakey, Fischer et al, 1988; Davies, Montez et al, 1987; Kroll, Carey et al, 1986; Rosenheck, Leda et al, 1989; Susser, Streuning et al, 1987; Gelberg, Linn et al 1988; Schutt, 1988; Mowbray, Johnson et al, 1986; Rosnow, Shaw et al, 1985; Crystal, Ladner et al, 1986; Roth and Bean, 1986; Morse, Sheilds, et al, 1985; Mulkern, Bradley et al, 1985).

Following the earlier method employed by Bassuk, all of the studies involved cross-sectional surveys and structured interviews of homeless subjects. The most consistent findings emerged in the description of demographic characteristics of the homeless persons surveyed. The eight single-city NIMH-funded studies summarized by Tessler and Dennis (1989), for example, found that the homeless were predominantly male (50 to 96 percent). The median age of homeless persons in these studies ranged from 29 to 38 years of age, a finding that confirmed that the homeless today are considerably younger than the skid row alcoholics of previous generations.

Five of the eight studies asked subjects about educational level and in each, about half reported that they had graduated from high school. In seven of the eight studies, less than 20 percent of the homeless were employed and fewer than one-third of the subjects

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TABLE 1: RESEARCH METHODS AND FINDINGS OF MAJOR STUDIES
OF HOMELESS MENTALLY ILL
1983 - 1989

STUDY	SAMPLE SOURCE	SAMPLE SIZE MALE/FEMALE (percent)	STUDY METHOD	DATA COLLECTION METHOD	MENTAL HEALTH NEED INSTRUMENT	% OF MENTALLY ILL			
						Schizophrenia	Affective Disorder	Personality Disorder	Organic Brain Disorder
Arce et al 1983	Shelter Census	N=179 78/22	Homeless Cross-Sectional Survey	Clinical Interview-Self Report	Psychiatric Evaluation (DSMIII)	34.4	5.6	6.7	5.0
Bassuk et al 1984, Boston	Shelter Census	N=78 82/18	Homeless Cross-Sectional Survey	Clinical Interview-Self-Report	Psychiatric Evaluation (DSMIII)	29.0	9.0	21.0	--
Fischer et al 1986, Baltimore	Random Mission	N=51 94/6	Homeless Cross-Sectional Survey	Structured Interview-Self Report	Diagnostic Interview Schedule DSMIII Diagnosis	2.0	2.0	11.8	7.8
Koegel et al 1986, Los Angeles	Random Shelters, Streets, Congregating Places	N=379 96/4	Homeless Cross-Sectional Survey	Structured Interview-Self Report	Diagnostic Interview Schedule DSMIII Diagnosis	11.5	20.9	17.4	--
Breakey et al 1988, Baltimore	Random Mixed Sites	N=194 64/36	Homeless Cross-Sectional Survey	Structured Clinical Interview Self-Report	Psychiatric Evaluation (DSMIII)	13.9	15.0	43.6	1.7
Davies et al 1987, Pittsburgh	Non-random SRO Shelter	N=24 88/18	Homeless Cross-Sectional Survey	Structured Interview-Self Report	Psychiatric Symptom Scales-DSMIII Diagnosis	20.8 CGO = 54% moderately to extremely ill	--	12.5	--
Kroll et al 1986, Minneapolis	Random Shelters	N=68 89/11	Homeless Cross-Sectional Survey	Structured Interview	Study Constructed Instrument	41% current or former contact with mental health system; 63% current/former substance abuse.			
Rosenbach et al 1989	Census Program Sites	N=10529 99/1	Homeless Cross-Sectional Survey	Structured Interview (Intake)	Study-Constructed Symptom Scale	48% one or more symptoms; 34.7% two or more symptoms			

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TABLE 1: RESEARCH METHODS AND FINDINGS OF MAJOR STUDIES OF HOMELESS MENTALLY ILL -- 1983 - 1989

STUDY	SAMPLE SOURCE	SAMPLE SIZE MALE/FEMALE (Percent)	STUDY METHOD	DATA COLLECTION METHOD	MENTAL HEALTH NEED INSTRUMENT	% OF MENTALLY ILL
Susser, et al 1989	Random "First-time" shelter users	N=177 100/0	Homeless Cross-Sectional Survey	Structured Interview	Study-constructed Structured Clinical Interview	12% definite psychosis; 5% probable; 8% possible; 75% negative
Gellberg et al, 1988	Non-Random Multiple Sites	N=529 73/27	Homeless Cross-Sectional Survey	Structured Interview Observation	Study-Constructed Symptom Scale	40% report psychotic symptoms; 19% observed to be psychotic
Schutt, et al 1988, Boston	Shelter Census	N=415 71/29	Homeless Cross-Sectional Survey	Structured Interview Self-report	Study-constructed Symptom Scale	21% psych. problems only; 20% dual diagnosis psych. and substance abuse, 20% alcohol only.
Mowbray et al 1986, Detroit	Random Shelter	N=75 71/29	Homeless Cross-Sectional Survey	Structured Interview Self-report	Mental Distress Scale	Men's scores BSI=average 90th percentile; Women's scores BSI=95th percentile
Rosnow, et al 1985 Milwaukee	Non-Random Shelters, Streets, Jails	N=237 80/20	Homeless Cross-Sectional Survey	Structured Interview Self-report	Study-constructed Symptom Scale	56% mentally ill.
Crystal et al 1986, NYC	Shelters Census	N=7,578 78/22	Homeless Cross-Sectional Survey	Structured Interview (Record Review)	Study-constructed Instrument	25% mentally ill.
Roth and Bean 1986, Ohio	Random/Non-Random Mixed Sites	N=979 81/19	Homeless Cross-Sectional Survey	Structured Interview Self-report	Study-constructed Symptom Scale	31% currently symptomatic; 65% require "structured, protective settings."
Morse, et al 1985 St.Louis	Random Shelter	N=248 51/49	Homeless Cross-Sectional Survey	Structured Interview Self-report	Study-constructed Symptom Scale	46% currently symptomatic; additional 22% mentally ill and abusing substances.
Mulkern et al 1985, Boston	Non-random Shelter Streets	N=348 81/19	Homeless Cross-Sectional Survey	Structured Interview Self-report	Study-constructed Symptom Scale	29% currently symptomatic; 15% mentally ill and abusing substances.

in six of the eight studies were receiving public assistance. In six of the eight NIMH studies. more than half of the subjects reported that they had never been married.

Beyond the general agreement in these demographic findings. there were sharp differences in the rates of mental illness found among the subjects in the 17 studies reviewed in Table 1. with the rate of mental illness ranging from 12 percent to 74.2 percent. For the six studies that assigned DSM III diagnoses. the range in Axis I non-substance abuse diagnos (serious mental illness) was from 23.6 percent to 74.2 percent. For the nine studies that measured mental illness based on reported symptoms. positive findings ranged from 12 percent to 56 percent. One study (Kroll et al, 1986) defined psychiatric need by past or current contact with the mental health system only (inpatient or outpatient). It found that 41 percent of its subjects had such contact. Finally, one study (Rosenbach et al. 1989) measured "mental distress" of its subjects using a standardized scale. The "average" subject in this study scored in the 90th percentile or higher. reflecting great distress.

Two additional studies focused on the experience of psychiatric hospital patients to observe the relationship between homelessness and mental illness. Mowbray. Johnson and Solarz (1987) studied admissions during a five-week period at a large state psychiatric hospital in Michigan. Of the 388 admissions. only 9 percent were persons who were homeless prior to admission. Although there are many factors that shape psychiatric hospital admission criteria and the findings do not purport to measure the mental health needs of the homeless. the low percentage of homeless persons admitted to

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the state hospital in this study suggests a weak association between homelessness and mental illness.

Belcher (1989) also used a sample of state hospital patients to determine the pattern of homelessness following discharge. One hundred thirty-two of 306 patients discharged over a four-month period from a state hospital in a Midwestern city of 1.5 million with an estimated single adult homeless population of 7,400, participated in a six-month follow-up study to determine residential status. Thirty-four persons (26 percent) were homeless at one month following discharge. The number grew to 44 (33 percent) at three months and decreased to 32 (24 percent) at six months. Thus, between a quarter and one-third of discharged patients experienced homelessness over the six-month period. Again, these findings do not suggest that state psychiatric hospitals are flooding the streets and shelters with the chronic mentally ill.

Methodological Problems in the Epidemiological Studies

As contradictory findings on the rate of mental illness among the homeless accumulated, researchers began to identify the underlying methodological problems that contributed to the divergent findings. These issues include: definitional and sampling problems; instances of small sample size; the complications of using cross-sectional and self-report data with the homeless and the validity and reliability of the mental health measures used. These concerns have been raised by both quantitative and qualitative researchers and, together, constitute an important critique of the epidemiological studies.

Definitional and Sampling Problems

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The definition of homelessness used in the epidemiological studies is clear in reviewing Table 1. The studies were limited to the "literally homeless," most often in shelters, streets, meal programs and other congregating areas. Tessler and Dennis (1989) and Susser, Conover and Streuning (1989) have identified the problems associated with this approach. First, it does not take into account the large number of persons found to rotate among short-stay residential situations. By excluding time as a factor in residential pattern, the studies do not capture an essential aspect of the marginally housed (Susser, Conover and Streuning, 1989). Second, the definition used does not include those who are "doubled up" with family or friends and who lack their own independent housing. In short, there is no way of knowing whether the population of a given shelter or "regulars" at a particular meal program are in any way representative of the homeless in general.

The sampling problems that follow from these definitional concerns are serious. In the absence of a known census of the homeless (Burnam and Koegel, 1988; Johnson, 1989), it is impossible in any geographic area to define a sampling frame in which all homeless persons have an equal probability of being selected (Tessler, 1990; Gelberg, 1988). In the non-shelter sites, particularly meal programs and congregating areas, there is an additional concern. In these settings, those who appear to be homeless may not be. Similarly, there are probably many homeless persons who do not fit the stereotypical physical description of the homeless (disheveled, unkempt, etc.) and who might not be approached by researchers. It is thus very difficult to achieve representativeness in the sample of the "street" population.

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These sampling issues are also relevant to the single-site shelter studies (10 of 17 studies reviewed). Here, there is no way to know whether the residents of a particular shelter are representative of the homeless in general; and there is strong evidence that they probably are not. In their qualitative study, Gounis and Susser (1990) have shown that shelters have strong cultures that shape the interactions of staff and residents and that given each shelter a unique character. Through this process of acculturation, some shelters might "screen out" certain persons (e.g., those who do not adhere to the cultural norms). Unless a shelter's culture is taken into account, there is a strong likelihood that undetected biases will influence study findings. None of the studies reviewed attempted to address this problem.

Susser, Conover and Streuning (1989) also point out that there is considerable variability among shelters in cities throughout the country in terms of size and pattern of use. The 1,000 bed barrack-style shelter is a very different environment than the 30-bed SRO-style shelter in which residents have their own rooms. In addition, several of the studies sampled residents of religiously sponsored missions, which are undifferentiated from shelters. Here again, key cultural variables and their impact on those who use a particular shelter or mission are ignored.

The Koegel et al Los Angeles study (1988) was the first attempt to create a sampling frame inside and outside of shelters. However, it still limited the study to "known" congregating spots of the homeless and did not address the problem of the "doubled-up" or other "invisible" homeless. Thus, while it was recognized as a model

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effort at the time (Tessler and Dennis, 1989), the methodological problems discussed above still make it very difficult to generalize the Koegel study's findings.

To summarize, in order to produce valid, generalizable findings, epidemiological studies must begin with a clear delineation of the population (sample frame) and then use a sampling method to achieve representativeness. Only one of the studies reviewed (Koegel et al, 1988) attempted to address these requirements. Furthermore, the comparability of the ten studies conducted in shelters is seriously undermined because of variations in shelter size, style, pattern of use and culture.

Sample Size Problems

Some of the studies had very small sample sizes, which also limits the generalizability of findings (Susser, Conover and Streuning, 1989). Excluding the total census studies, four studies had n = <100. The Fischer et al study (1986) is a good example of the possible effects of too small a sample. In this study a random sample of 51 persons from four shelters was interviewed using the Diagnostic Interview Schedule (DIS), a standardized instrument, to make DSM III diagnoses. For schizophrenia, rates in other studies ranged from 11.5 percent to 34.4 percent, compared to Fischer's 2 percent. Similarly, other studies had found rates of affective disorders ranging from 5.6 percent to 20 percent, again compared to Fischer's 2 percent finding.

In the case of the Fischer study, the homeless sample data were compared with the results of an NIMH household study in the same geographic area. A similar study design (Koegel et al, 1988), comparing rates of schizophrenia and affective disorders between randomly selected homeless persons and household using the DIS was conducted in Los

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Angeles. The results, including the prevalence ratio between homeless and household rates are reported in Table 2.

Table 2 indicates that in the Fischer study, in addition to finding very low rates of schizophrenia and affective disorders among the homeless, the increased risk of the homeless having a major diagnosis compared to all households was far less than in the Koegel study. Koegel's findings, consistent with all other studies, found that being homeless increased one's risk of being diagnosed with schizophrenia by more than 38

TABLE 2

Reported Rates of Schizophrenia and Affective Disorders and Prevalence Ratios in Fischer and Koegel Studies (in Percent)

	Fischer et al n=51			Koegel et al n=379		
	Homeless Rate	**Household Rate**	**Prevalence Ratio**	**Homeless Rate**	**Household Rate**	**Prevalence Ratio**
Schizophrenia	**2.0**	**.4**	**5.0**	**11.5**	**.3**	**38.3**
Affective Disorders	**2.0**	**1.9**	**1.05**	**20.9**	**3.4**	**6.1**

times, and homeless persons were six times more likely than householders to be diagnosed with an affective disorder.

In the Fischer study, on the other hand, homeless persons were diagnosed with schizophrenia only five times as often as householders, and there was almost no

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additional risk (1.05) of the homeless being diagnosed with an affective disorder. (Indeed, the rate of schizophrenia found in the Fischer study is only twice the overall national rate, and the rate of affective disorders is about the same as the national rate.)

The small size of the Fischer sample was probably a significant factor in obtaining its anomalous results.

Cross-sectional and Self-Report Data

All of the studies reviewed used cross-sectional (one-time) surveys and relied on information provided directly by subjects (self-report data). Using these methods with the homeless has increasingly been called into question (Lovell and Shern, 1990; Koegel and Overbo, 1990; Tessler and Dennis, 1989; Hopper, 1988; Koegel, 1991; Morse and Calsyn, 1992)).

The cross-sectional approach has been criticized on two grounds. First, it cannot accurately portray a causal relationship between homelessness and mental illness because it can only give a "current picture" of those sampled. As Hopper (1988) points out, there is no way of knowing whether what is being currently observed is "antecedent to or consequent of" the homeless condition. In order to achieve this kind of understanding, there is an acknowledged need to study the homeless longitudinally (Koegel, 1990; Rosenheck and Fischer, 1989; Dennis, Buckner, et al, 1991), a corrective approach recommended by both quantitative and qualitative researchers.

Second, cross-sectional data are context-specific. That is, the qualitative researchers have shown that the behavior of homeless persons may change dramatically from setting to setting (Koegel, 1991). This phenomenon cannot be captured by cross-

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sectional sampling at a single time. Again, the question of facility culture is of great importance here. As Gounis (1992) has demonstrated in the case of shelters, homeless facilities powerfully affect residents' behaviors and responses. The rigid structuring of time in shelters, for example (scheduling of sleeping arrangements, showering, meals, contacts with services staff) powerfully shapes resident behavior. This important dimension is not addressed in the typical cross-sectional survey. It is suggested that subject responses may therefore be more context-conditioned than they are reflective of a subject's individual characteristics.

These issues are confounded further by the epidemiological studies' reliance on self-report data. Belcher (1989) pointed out that relying on self-reports of homeless persons is especially problematic, since they are often afraid, suspicious or angry. Several other authors have indicated that the homeless may not be good reporters (i.e., they may under-report such emotionally-charged experiences as psychiatric hospitalizations or time spent in prison). There may also be great discrepancies between what subjects report and their actual behavior. This critique has been especially strong from the qualitative researchers who stress observation rather than subject reports (Koegel, 1987; Gounis, 1992; Snow et al, 1986).

For example, many of the epidemiological studies concluded that the homeless are severely isolated socially. They reached this conclusion by asking subjects about social contacts. The Bassuk study (1984) reported that 74 percent of its subjects had no family relationships and 73 percent had no "supportive" relationships. However, when Lovell and Sokolovsky (1989) conducted an ethnographic study of 281 homeless men on

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the Bowery and observed their social patterns, they found almost no totally isolated men. Although the subject's social networks were smaller than a comparison group of domiciled men (6.0 for the homeless compared to 9.6 for the domiciled), it was clear that they had considerable social contact and support. The study even documented that all subjects had at least one family tie. Koegel (1991) cites similar examples from his ethnographic fieldwork. Several subjects previously reported by shelter and program staff to be total isolated were observed to have regular social contact.

The question of disaffiliation and social isolation is thus more complex than the epidemiological studies indicate. In relying on cross-sectional, self-report data, they were unable to distinguish between situational responses and more persistent patterns of behavior. Longitudinal study and observation are two important corrective techniques that would overcome these problems.

Validity and Reliability of Mental Health Measures

As Table 1 indicates, the methods of determining mental illness in the 17 studies varied considerably. Some studies relied on clinical interviews by mental health professionals, several used standardized scales with additional items. Not only does the variety of instruments raise validity and reliability questions, it also means that because of methodological differences, the findings on the rates of mental illness cannot easily be generalized or compared (Koegel and Burnam, 1992; Robertson, 1986; Tessler, 1990; Dennis, Buckner et al, 1991).

Virtually none of the studies conducted validity studies to determine whether the instruments used (either standardized or specially constructed) were "properly calibrated"

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to detect mental illness in a homeless population (Susser, Conover and Streuning, 1989). Even the application of standardized instruments to the homeless is highly questionable, since theses instruments were developed on clinical populations, not a marginal, highly mobile group like the homeless (Tessler and Dennis, 1989; Milburn et al. 1986).

For example, the Koegel et al (1988) Los Angeles study used the standardized Diagnostic Interview Schedule. In determining the diagnosis of anti-social personality disorder, three of the questions used to score subjects relate directly to the state of homelessness (not having a regular place to live, not working for six months or more, having three or more jobs in the past five years). Applying these "diagnostic" criteria to the homeless has a tautological quality since these are typical correlates or conditions of homelessness. Not surprisingly, then, when Koegel removed these three questions from the DIS protocol, the incidence of anti-social personality disorder dropped by 10 percent.

Those studies which used generic clinical interviews by mental health professionals to determine diagnoses (Arce et al, 1983; Bassuk et al, 1984) did not use standardized protocols, nor were special training for interviewers or reliability studies conducted. Across all studies, validity issues are also raised in light of the discussions above of the limitations of self-reporting and data collected at a single point in time. The single time issue is especially important since the studies could not gauge whether symptoms were transient or persistent. Again, this is a strong argument for the need for longitudinal studies.

Validity is also seriously jeopardized by potential misinterpretation of behavior as pathological. Martin (1982), for example, demonstrated that the layering of clothing or

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poor personal hygiene can be protective adaptations for homeless women who have no storage facilities and who are concerned with protecting themselves from physical assault. Other qualitative researchers have documented additional adaptive behaviors which may "look" pathological (i.e., non-compliance with medication to assure alertness, paranoia as a protective defense) (Snow et al. 1986).

Similarly, the exigencies of homeless life, including poor nutrition, sleep deprivation and unsafe living conditions may create "symptoms" similar to depression or other psychiatric disorders. Often, then, what may appear to be symptoms of mental illness might actually be acute reactions to situational factors. Indeed, Goodman, Saxe and Harvey (1991) suggest that the psychological "symptoms" of homelessness can be best understood, not as persistent pathology, but as the result of the trauma that precipitated it and the situational reaction to it.

In terms of environmental factors, for example, Gounis (1992) and Grunberg and Eagle (1990) have described extensively the realities of everyday life in shelters -- a mix of crime, involvement in drugs, theft, rape and other illegal activities, and rigidly structured routine. Residents must adapt to these realities by either participating or developing strong defensive measures such as bizarre or paranoid behavior which will protect them. These defenses may easily be labeled signs of mental illness.

To summarize, in order to validly measure and account for mental illness in homeless persons, instruments and methods must be used that take account of the situational, environmental and adaptive norms of homelessness (Koegel, 1987; Susser,

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Conover and Streuning, 1989). These issues were not adequately addressed by the epidemiological studies of the 1980s.

The Ethnographic Approach

Koegel (1987, 1991) has described the major features of the ethnographic study of the homeless and summarized its findings. In introducing the concepts of ethnography, Koegel underscores the implications of the methodological limitations of the epidemiological studies:

> Our over-reliance on a quantitative approach is one piece of the legacy we have inherited from our preoccupation with an epidemiological perspective. Equally trenchant has been an overwhelming pre-occupation with pathology, disintegration and disaffiliation, a trend which clinicians who are trained to view their clients through a lens that highlights individual pathology and functional impairment, share responsibility. Almost exclusively, the emphasis has been on what is wrong with the homeless mentally ill [emphasis added] (1991, p. 6).

As a corrective, Koegel suggests qualitative, holisitic study of the homeless through "detached" participant observation. The goal here is "to understand what the world of the homeless is like and how they perceive it" (1991, p. 11).

The major corrective elements of this approach are: (1) the study of behavior in context, both the immediate context of daily routines and the broader context of homelessness as a phenomenon of social structure (pauperization, response of the welfare system); (2) the study of behavior over time, to determine patterns of behavior and survival as well as changes/transitions in homeless persons' lives; (3) the substitution of observation for self-report in order to "know" first-hand what homeless persons do, rather than relying on subjects' self-reports; (4) the pursuit of the "insider's point of view," in

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order to understand the world as the homeless experience it and how they view their choices.

In summary, the major findings of ethnographic research on the homeless to date are:

1. The homeless are highly diverse, mobile and heterogeneous as a group. Patterns of residence studied over time reveal significant mobility. Homeless persons often cycle rapidly through "short-stay" situations, including shelters, streets, friends and relatives (Barrow, Hellman, Lovell et al, 1989; Stark, 1985; Strasser, 1978). Heterogeneity is also apparent in the range of functional level, and in the way homeless persons define their problems and needs (Koegel, 1987).

2. A longitudinal prevalence study conducted by Snow et al (1987) in Austin, Texas and which used ethnographic as well as quantitative methods, found much lower rates of mental illness among the homeless than the epidemiological studies. For a non-probability study of 144 "street" people engaged over a period of several months, 9 percent were designated as mentally ill (by meeting two of three criteria: prior institutionalization; designation of mental illness by researchers through observation of bizarre or situationally inappropriate behavior; or designation as mentally ill by other homeless persons). A second sample of 747 persons who had used the local shelter system -- the "tracking sample" -- was studied to determine their history of diagnosis, institutionalization or contact with local mental health agencies. Using these criteria, 16 percent of the "tracking sample" was designated mentally ill. Taking into account an

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overlap of 20 subjects in both samples, the combined rate of mental illness was 15.0 percent.

3. The precipitants of homelessness were generally found in a gradual "slide" rather than in a single traumatic event. In this downward spiral, the homeless often found themselves unable to maintain the economic resources needed to continue living in conventional housing or they became estranged from family or friends who supported them (Merves, 1986). Social and economic marginality and lack of back-up resources (not mental illness) were found to be the key precipitants.

4. A related finding has been the surprising strength of conventional role definitions which many of the homeless maintain (Snow and Anderson, 1987; Guarnaccia and Henderson, 1993). As summarized by Koegel (1987), most ethnographic studies have documented that homeless persons continue to identify themselves in conventional roles: parent, spouse, worker, friend, child, etc. The persistence of role identifications is striking and has been shown to be of great psychological importance to persons who are otherwise materially and emotionally distressed.

This phenomenon has been shown to be directly related to the "resistance" of the homeless to mental health services. Taking on the role of "mental patient" is viewed as "role engulfment" that threatens the sustaining role identities that many homeless maintain (Koegel, 1987).

5. In shifting the focus of study from pathology to the homeless person's point of view, the concept of "treatment resistant client" is discarded and the concept of "treatment resistant service provider" is substituted. Several ethnographic studies have shown that

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the most important barriers that prevent the homeless from receiving services are what they perceive to be the demands and rigid requirements of service providers (i.e., formality of services, restrictive admission criteria, location of service). The homeless have consistently expressed a strong preference to have basic needs (including housing and employment) addressed <u>before</u> mental health services. This does not reflect a denial of mental health problems as much as it does the immediacy of subsistence needs and the desire to maintain positive role identity (Koegel, 1992; Koegel, 1987; Barrow and Lovell, 1983; Barrow, Hellman, Lovell et al. 1989; Plapinger, 1988; Herman et al. 1994).

6. One of the more controversial suggestions of the ethnographic research is that the techniques of ethnography (gaining trust, entering into the subject's world, etc.) can serve as a model for service development and delivery. Koegel (1987) proposes that just as ethnographic researchers gain knowledge through acceptance of their subjects and respecting them as "experts on their own lives," it would be beneficial for service providers to adopt similar methods of understanding to develop responsive programs.

Summary and Conclusions: The Policy and Methodological Implications of the Research on Homelessness and Mental Illness

As stated at the outset of this review, a key step in public policy making involves the framing of problems in order to define their dimensions which, in turn, suggests solutions to be formulated into programs. Thus, the epidemiological studies of the homeless were more than "counting" exercises. Their characterization of the homeless created a public mindset that shaped governmental action at all levels. The stakes in portraying the homeless accurately were and continue to be extremely high.

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Once established, the public mindset defines the boundaries of social attitudes, conditions the public's motivation to address a problem and sets the range of alternative solutions. Hopper (1988) suggests that a deviance model of homelessness (what he calls "impaired capacity") which views the individual as psychiatrically disabled, will yield a very different policy discussion than a "social dispossession" model, which views the roots of homelessness not in individual psychopathology, but in larger social developments in housing, employment and government assistance policies. The former model "blames the victim," the latter views social victimization as a key factor.

The limitations of the epidemiological approach to the study of homelessness have been a central concern of this review. Problems in sampling method, the use of cross-sectional data collected at a single point in time, the validity and reliability of self-reports and instruments used to determine mental illness and the misunderstanding of situational behaviors (and the norms of homelessness), all contributed to a large body of contradictory and misleading findings.

In 1986, Robertson warned that in the wake of studies that showed very high rates of mental illness among the homeless, new stereotypes were being created. Five years later, Dennis, Buckner, Lipton and Levine (1991) attempted to portray the epidemiological studies in the most positive light possible: "It has taken considerable data and time to dispel the belief that the majority, if not all, of the homeless population are mentally ill." (p. 1130). While admitting that prevalence figures for mental illness among the homeless varied widely, they settled on the view that a 28-37 percent estimate of prevalence is appropriate based on those studies that used standardized instruments.

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However, given the methodological problems discussed in this review and the fact that even the standardized instruments were never validated for a homeless population, their confidence was surprising.

With many of the critiques of the epidemiological studies in mind, efforts to document the number of homeless and percentage of mentally within the population continued in the 1990s. Taken as a group the studies of the 1990s continued to suggest correctives in conducting quantitative research, problems of counting and diversity within the homeless population and methods of refining estimates of the homeless in general and the mentally ill homeless in particular (see: Atkinson et al, 1997; Bellavia and Toro, 1999; Bates and Toro, 1999; Burt,1996; Fischer, 1991; Hudson, 1998; Link et al, 1993; Phelan and Link, 1999; Link et al, 1994; North, 1998; Robertson, 1992; Rosenheck et al. 1998; Snow et al. 1994; Straw, 1995; Toro et al, 1999 ; Wright and Devine, 1995; Bassu et all, 1998; Burt, 1992; Burt, 1998; Haugland et al, 1997).

The ethnographic critique of the epidemiological studies begins with a different set of assumptions about the homeless. Rather than viewing them as chronic mental patients and categorizing them as "cases" who primarily require "treatment," the ethnographic researchers view the homeless as situationally disadvantaged. Thus, the focus of intervention is response to the elements of disadvantage -- in the short run, the provision of basic subsistence services including housing, food, clothing and medical care: in the long run, stable quality housing, income through employment or entitlements and needed ongoing health, mental health and rehabilitation services.

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With the ethnographic correction in mind, the challenge now, at one level, is to deepen our understanding of the culture of homelessness with the intent to develop effective program strategies. At another level, the distractions of the epidemiological debate can be put aside and more attention can be directed to the broader economic and social factors underlying homelessness (i.e., housing and employment policy). It should be stressed that the defects of the epidemiological studies of the homeless were not inherent in the quantitative methods themselves, but in the way in which those methods were applied to a cultural context without adequate knowledge of that context. As we have seen, the ethnographic approach provides such contextual understanding, which can then inform the design of valid and reliable quantitative studies.

The research on the homeless thus illustrates crucial lessons for those who are seeking to understand social problems, the crucial first step in addressing them. As this review has demonstrated, it is clear that the research paradigm itself can and does have significant impact on the findings of social researchers.

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CHAPTER 2

The Program Response to the Mentally Ill Homeless: The Search for Excellent Programs

While efforts continued throughout the 1980s to identify the causes of homelessness and the debate between the epidemiologists and ethnographers also continued, government officials were galvanized into action as the numbers of homeless increased and their impact on the local quality of life was felt more intensively. For example, bowing to legal and public pressure to respond, New York City signed a court-mandated Consent Decree in 1982 in which the City agreed to provide shelter beds, meals and bathing facilities for all homeless persons (NY Post, 1982). In the wake of this agreement New York's public shelter system for single adults grew from less than 4,000 beds to 10,000 beds over a two-year period.

Program efforts were mounted throughout the nation, largely initiated by local and state governments in a crisis atmosphere. Federal homeless policy took shape slowly. Beyond the NIMH-sponsored research discussed in Chapter 1, the government created two major program initiatives, the Stuart B. McKinney Homeless Services program administered through the Department of Housing and Urban Development, including a "Shelter Plus Care" program for the mentally ill homeless and the ACCESS Programs, targeted to reach and serve the mentally ill homeless. (For discussions of the major federal programs and initiatives for the homeless and mentally ill homeless see: Adler, 1991; Barrow et al, 1992; Borowitz, et al, 1995; Center for Mental Health

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Services. 1994: Center for Mental Health Services. 1997: Fosberg et al. 1994: Fosberg et al. 1997: Interagency Council on the Homeless. 1991; U.S. Department of HUD. Office of Community Planning. 1997a. 1997b; U.S. Department of HUD. Interagency Council on the Homeless. 1999).

At the state and local levels programs were developed to respond to homelessness generically and to the special needs of the mentally ill homeless in particular. (For recent evaluations and discussions of methodological issues in evaluating programs for the homeless at the state and local levels see: (Bybee et al, 1995; Cohen et al, 1993; Johnson and Hambrick. 1993; Mercier et al, 1992; Barrow et al. 1996; Morse et al. 1992; Mowbray et al. 1993; Rog, 1991).

This chapter presents a study conducted by the author in 1992 that reviewed the early range of programmatic responses developed, discusses the content of model "excellent" programs and. perhaps most importantly, presents an analytical framework that can be applied in examining the structure of social programs. The effort here is to develop a set of generic tools to capture the essential elements of programs under study.

Framework for Analysis

Just as we demonstrated that "framing" is a natural process in the public policy debate concerning identified social problems. it is also true that social work intervention may be understood as emanating from a process of "framing." Lewis (1982) defines social work as a "synthesized practice science" in which the worker uses "intellectual tools" to "engage the recipient in action (the service) which is designed simultaneously to

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alter favorably the recipient's (unfavorable) condition and to reduce the recipient's future dependence on service" (p. 36).

In this process, the worker uses both the "segmented orienting knowledge" provided by the basic sciences (i.e., how "economic man" acts "economically;" how "social man" acts "socially;" how "psychological man" acts "psychologically," etc.) and the "how to" knowledge which is reflected in the principles of social work practice. These two knowledge bases are synthesized into social work practice.

Lewis' suggestion that social work is ultimately concerned with recipient change or alteration and a reduction in his/her future reliance on service, highlights the reality that every social program is organized around a "theory of help" to achieve the desired changes. These ideas were used by the author to construct an analytical framework for a descriptive study of programs for the mentally ill homeless.

Following Lewis' concepts, the framework identifies five critical program dimensions to be analyzed: 1) the view of the client's problem; 2) the program's explicit theory of help; 3) the program's implicit theory of help; 4) the program's scope of services; and 5) how the program organizes the "episodes of service" for the clients it serves.

1. View of the Client's Problem:

As discussed in Chapter 1, the "framing" of a social problem usually constitutes both a problem definition and the programmatic "solution" that follows from it. In terms of understanding a program, the place to begin is with the way in which it views the client's problem. It is this view which the program incorporates into its "theory of help."

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The view of the client may be either explicitly articulated or may have to be inferred from an understanding of program elements (Merton's [1981] "manifest" or "latent" levels). including the content and/or organization of services. As we shall see. the programs analyzed in the study reported in this chapter view the mentally ill homeless differently. These differing views are at the heart of how each program views its mission and defines its scope of services.

2. Explicit Theory of Help:

The program's articulated view of the client's problem is used to construct an explicit "theory of help." The term help here is closely allied to the concept of "change." Programs bring resources to bear on what they perceive to be the client's needs in order to change something about the client.

The changes that programs seek in clients may be "external." such as improving his or her living situation by providing material services or support (i.e.. housing, income benefits. health care services, job training). Or the changes sought may be "internal" (psychological or emotional growth or development, feelings of competence or empowerment). Many programs seek both external and internal changes by trying to improve the client's material condition, while enhancing his or her "internal" abilities in order to reduce future reliance on services (see Lewis [1982], pp. 17-38).

3. Implicit Theory of Help:

Whether a program seeks "external," "internal" or both kinds of change in clients. the articulated theory of help always reflects an "implicit" theory of the client's problem and how people "change." These implicit theories can range broadly from structural or

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ideological statements about the organization of social, economic or political life to theories of individual development or psychology. The implicit theory of help thus contains specific statements about how the client can be expected to achieve the kind of change that the program envisions.

4. Services:

The view of the client's problem and "explicit" and "implicit" theories of help are reflected in the scope and organization of services that the program provides. The scope and content of services represent the distillation of the program's view of what the client needs (or needs to do) if change is to be achieved. But a mere listing of service does not convey the whole picture. The organization of services is an equally important prescriptive element. Services that are organized to maximize the client's acquisition of skills for future self-reliance, coping and adaptation are different from services organized simply to provide clients with specific material benefits (housing, food, medical care, etc.) or psychological support. The services that programs offer, then, must be understood in terms of their range or content and the way in which they are organized. Both dimensions relate directly to achieving client "change."

5. Episode of Service:

One of the best ways to understand how programs actually operate is to follow a client's progress through the program's defined "episode of service," what Taber and Finnegan (1990) call the "natural history of service provision." This is the longitudinal process through which programs induct clients and "process" them to achieve the desired change. In following the episode of service, the analyst is identifying what clients

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actually experience in the program over time. Similarly, the episode of service will indicate how staff and other program resources are allocated and the staff functions and roles that are identifiable as the client is "processed" through the program.

The Search for Excellent Program: Method of Study

This study reported in this chapter used a "reputational" method to identify programs of excellence for homeless mentally ill single adults. The method was selected so that the investigator could conduct a national search, contacting leaders in government, research foundations and academia familiar with such programs. The study design was to compile the respondents' criteria of excellence and to determine if there was consensus in either the criteria themselves or in the selection of "excellent" programs. It should be mentioned that there are very few published evaluation studies or reports on programs for homeless mentally ill adults. Rog (1992) has discussed the methodological issues involved in designing such research. Thus, the reputational method used by this study is especially well-suited in instances where new program efforts are being developed at a time when there is little previous documented or evaluated program experience.

In late 1993, Six national figures were contacted. They comprise the reputational respondents' group:

1. The immediate-past Director of Homeless Programs at the National Institute of Mental Health

2. The Director of Community Support Programs at the National Institute of Mental Health

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3. The Director of the National Resource Center on Homelessness and Mental Illness (a non-profit foundation supported with federal funds)

4. A psychiatrist who has been a national leader in advocating for and creating services for the homeless and chronic mentally ill and who headed the Robert Wood Johnson Foundation's multi-city demonstration program for the homeless mentally ill

5. The immediate-past Director of Evaluation of Homeless Programs at the National Institute of Mental Health

6. A leading national researcher on the homeless mentally ill at the University of California at Los Angeles, who has conducted extensive quantitative and qualitative research.

The subjects were interviewed by telephone, using an open-ended interview guide in which they responded spontaneously to broadly framed questions about their perceptions of "excellent" programs. They were asked to formulate "criteria of excellence" and to identify programs that they believed met these criteria. Table 3 presents the list of criteria compiled on the basis of the six interviews. The figures in the right column are the number of respondents who specified that particular criterion. Thus, if all respondents named a specific criterion, it would be scored with a perfect six.

TABLE 3. "Criteria of Excellence" Named by Respondents

Criterion	Number of Respondents Who Named Criterion
Multi-Service Approach (outreach, housing, case management)	5

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Advocacy/Support System	5
Case Management (not psychiatric treatment)	4
Active Outreach (engaging clients in their settings)	4
User Friendly (flexible hours of operation. informal appointment scheduling. etc.)	4
Integration with Other Services	4
Individualize Client	3
Flexible (no rigid biases toward client)	3
Clear Idea of Who Gets Served	3
Clearly Defined Mission/Vision	2
Strong Leadership	2
Client Empowerment	2
Demonstrate Effectiveness	1
Consumer Input in Formulating/Operating Program	1
Single/Narrow Focus	1

In analyzing these data. it is clear that the respondents expressed a strong preference for programs that use a multi-service approach that includes at a minimum outreach. housing and ongoing case management. In contrast. only one respondent

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thought programs should have a single focus (e.g., housing only, without case management or other services).

In keeping with the preference for a multi-service approach, five respondents also expressed the belief that excellent programs for the homeless mentally ill have strong advocacy components and offer clients a general support system. This feature was usually linked to the belief that the client group has multiple needs (for concrete services such as government income and medical entitlements, health care, housing, mental health and rehabilitation services, including vocational training and education). Respondents felt, therefore, that programs must incorporate an overall advocacy strategy (ongoing assessment and linkage of clients to services) in a supportive environment (the vulnerabilities of the clients' psychiatric conditions and their histories of homelessness and "social detachment" elicited the strong opinion that programs should offer advocacy and concrete services in a highly supportive milieu).

Consistent with this thinking, four of the respondents conceptualized the basic program concept as case management, in contrast to treatment. This approach has been developed over the past decade at the National Institute of Mental Health's Community Support Programs (CSP) initiative for the chronic mentally ill. At its core, CSP views a primary task of community programs for the chronic mentally ill (homeless or not) as providing support and linkage to the full range of services that clients need. The distinction here is between the recognition of the multiple needs of the client in contrast to the previous primary emphasis on psychiatric services (i.e., medication). The

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respondents in this study expressed a strong preference for the CSP case management. multiple-need approach.

In keeping with the supportive case management approach. four of the respondents stressed that excellent programs for the homeless mentally ill actively reach out to clients in the community. should be "user friendly" (offering services in a way that is acceptable to clients. such as flexible appointments or service locations) and should be integrated with other services (the linkage concept).

Consistent with the recognition of clients' multiple needs. three of the six respondents said that excellent programs are those that are able to "individualize" clients. These respondents were concerned about the program having the ability to recognize and respond to individual differences among clients and to tailor service accordingly. Flexibility of service. a related concept. was also mentioned by three respondents.

On the other hand. individualization has its limits. Three respondents believed that it is essential for programs to have a clear idea of who gets served. This reflects the reality that within the general homeless mentally ill group. there are a number of significant sub-groups that have a variety of specific needs to be addressed (i.e.. co-occurring substance abuse. persons with HIV/AIDS. persons with minor children). To these respondents. a clearly defined target population is essential so that they can identify clearly the specific programmatic and organizational issues they are prepared to address. Thus. three respondents believed that a clear definition of the target population is essential in developing excellent programs.

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A number of the criteria of excellence least mentioned by respondents relate directly to organizational matters. As mentioned above, one respondent thought that it was important for programs to have a single or narrow program focus. Two respondents mentioned that it is essential for a program to have a clearly defined mission or vision of their work. While not mentioned explicitly by the other four respondents, this requirement was certainly implied in the way all respondents conceptualized work with the target group. The strong support of the previously discussed CSP approach, for example, indicates conviction about the primary mission of "excellent" programs (i.e., the client with multiple needs being provided with and/or linked to the full range of needed services).

Two respondents mentioned the importance of strong organizational leadership as a requirement of excellent programs. Again, this relatively small number may not be surprising in light of the respondents' greater focus programmatic rather than organizational issues. Although, as we have seen, there is a strong belief that programs must offer "client-oriented" services, only two respondents specifically mentioned client empowerment as a criterion of excellence and only one respondent identified the importance of a role for clients in designing and operating the programs that serve them. The significance of other respondents not mentioning client empowerment or an appropriate role for clients in the design and operation of the services was not explored further in this study.

Finally, only one respondent cited demonstrated effectiveness as a criterion of excellence. This probably reflects the state of the services network at the time than a

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disinterest in program documentation or evaluation. The study was conducted at a time when the service network was still in a formative stage of development. Typically, the three programs selected for the case study section of this study have not been formally evaluated nor have they published findings on program outcome.

Summary

When asked to define the criteria of excellence for programs that serve the homeless mentally ill, the six respondents focused mainly on programmatic elements, expressing a strong preference for a multi-service (as opposed to a single focus) approach that provides clients with support and advocacy in obtaining the services they need. A case management approach that addresses the range of client needs is preferred to a single (psychiatric treatment) orientation. There is also a strong preference for an integrated service model that provides flexible, "user friendly" services.

Organizational elements such as strong leadership, clearly defined mission and client participation in program development were less frequently mentioned. Demonstrated program effectiveness was cited by only one respondent.

Analysis of Excellent Programs

When asked to name excellent programs for homeless mentally ill adults, the six respondents listed a total of 28 programs. Despite the fact that the respondents were all familiar with programs located throughout the country, there was remarkably little duplication among the six lists. For purposes of the analysis, the author selected three programs from among the respondents' lists, two in a large eastern U.S. city and one in a

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large west coast city. In order to protect confidentiality, the names of the programs were changed for this study.

Table 4 (p. 43) uses the five-element framework of analysis presented above to compare the three "excellent program" under analysis. The Table illustrates significant differences in the view of the client and explicit and implicit theories of help. The difference in the range of services offered and episode of service are also pronounced, although less so. We turn now to an analysis of each program individually using the framework and then to a comparative discussion.

Program 1: Upward Community Services (UCS)

Upward Community Services (UCS) was founded in 1980 as a service program sponsored by a university in a large eastern city. The founder of the program, a masters level social worker, was employed by the university's medical school's department of psychiatry. At the time of the study, the program was still university-affiliated, although it subsequently became independent. At the time of the study, UCS operated the following programs:

1. A 40-bed Transitional Living Community (TLC) for mentally ill homeless located within a large municipally operated shelter. The purpose of the TLC is to prepare participants to assume independent housing in the community.

2. A direct case management and social services program in six housing sites, ranging in size from 21 to 650 units, for formerly homeless persons. UCS directly owns two of the sites and provides contracted services in the other four.

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3. A drop-in center to engage street-dwelling homeless and to work with them in preparation for independent housing.

Table 4. Comparison of Three Selected Programs By Elements of Study Framework

Framework Element	Upward Community Services (UCS)	The Living Place (TLP)	Project Hope (PH)
View of client as...	Victim of social system Failures	Psychologically estranged	Psychiatrically impaired
Explicit Theory Of Help	Entitlements, benefits & resources to achieve & maintain housing	Therapeutic milieu/attach-ment; concrete & rehab services	Medication to achieve stability for housing/rehab
Implicit Theory Of Help	Negative social, economic and political forces can be overcome; "beating the system"	Principles of developmental & ego psychology	Medical Model
Services	-Housing readiness -Housing placement -Assistance in maintain-ing housing	-Pre-housing milieu program -Housing services -Rehab services	-Psychiatric services -Housing referral -Structured socialization
Episode of Service	-Obtain benefits -Achieve housing placement -Support services to maintain housing	-Drop In/Engage-ment -Benefits -Housing -Rehabilitation	-Psychiatric assess-ment -Psychiatric ser-vices -Housing referral -Structured sociali-zation

4. A contracted clearinghouse program that publishes monthly a listing of available homeless housing openings throughout New York City.

5. A technical assistance and training program for organizations that want to develop or are currently operating housing for homeless persons. Services include

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assistance in the design and capital development of homeless housing projects and staff training on working with homeless persons in residential settings.

UCS View of the Client

Although created under the auspice of the department of psychiatry of a university-based medical school, UCS has the most politically and ideologically defined view of the client and theories of help of the three programs (the material in this section is based on a series of interviews with the UCS executive director). The program views homeless mentally ill persons as victims of political and economic systems failures.

In terms of the Chapter I discussion of "framing" the problem of homeless mentally ill, the leadership of UCS subscribes to the view that the excesses of U.S. capitalism beginning in the mid-1970s (loss of manufacturing and unskilled jobs and structural unemployment, reduced social benefits, suspension of development of public housing) caused the crisis of homelessness in general and the homeless mentally ill in particular. Given this structural analysis, UCS de-emphasizes the client's mental health problems, stressing a radical critique of the basic U.S. economic and social systems. The client, then, is not seen either as primarily responsible for his or her disadvantaged condition, nor is the client assigned a primary identity as "mental patient." UCS clients are viewed as disadvantaged victims of an abusive and unjust "system."

UCS Theory of Help

Following from this, UCS' explicit theory of help focuses on assisting clients in obtaining the specific entitlements, benefits and resources needed to achieve and maintain housing. This is interpreted primarily as economic resources (income, entitlements, rent

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subsidies, etc.). As discussed above, this emphasis is also reflected in the agency's advocacy and technical assistance in the development of new housing and in the monitoring of the existing housing network to assure that resources are being fully utilized. It is a singular focus on housing, then, that is at the heart of the UCS program.

The implicit theory of help suggests that the negative results of U.S. capitalism and its attendant social philosophy (i.e., the clients' poverty and homelessness) can be overcome with concrete assistance by: (1) using knowledge of "the system" to obtain available benefits; and (2) "working with the system" to advocate for the creation of additional housing resources and benefits. The implicit theory, then, stresses "beating the abusive system at its own game."

UCS Services and Episode of Service

Since the view of the client and theories of help define housing as the client's central problem, the services that UCS offers are clearly designed and organized to assist clients in: (1) obtaining entitlements needed to achieve it (income benefits and rent subsidies); (2) finding the housing itself and (3) maintaining it.

In plotting the course of service, UCS uses a "Gantt Chart" format. The clients engaged in the Transitional Living Community or through the drop-in program are prepared for housing in a six-to-nine-month period. The staff, comprised largely of paraprofessionals with a very small number of social workers, draw up a milestone chart for each client. Program design works "backwards" with the housing placement identified as the ultimate goal and then moving back in time, specifying the objectives and milestones that must be achieved.

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The program assigns uniform timeframes for accomplishing major milestones (i.e., obtaining Social Security disability benefits, Section 8 rent subsidy vouchers, etc.). Program supervisors monitor the staff's performance in achieving each milestone. Once all benefits and entitlements are in place, the major task becomes locating a suitable housing accommodation for the particular client. UCS prefers to place clients in generic housing as opposed to specialized (in their term "segregated") housing for the mentally ill. Again, this reflects the agency's non-stigmatizing approach and its definition of the problem as "generic poverty."

If the client is moving into one of the six buildings in which UCS is the service provider, then the on-site team assumes case responsibility. If the client is placed in a non-UCS-serviced facility, UCS follows the client's progress for a 90-day period, providing support and addressing any problems, after which the client is officially discharged from UCS.

At the point at which clients are placed in the housing, whether in a UCS-serviced facility or not, the UCS staff begins to broaden its concerns for the client beyond concrete income benefits and housing services. The director acknowledged that at this stage in helping client maintain housing, it may be necessary to use a more traditional mental health case management approach. Here, counseling, mental health and/or substance abuse services and health care needs assume greater importance, along with "tenant" concerns such as paying rent on time and not disrupting other tenants.

Thus, the "change" UCS envisions for its clients is primarily in their "external" condition of homelessness. This change is achieved through the permanent housing

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placement. "Internal" matters (the client's mental illness and related issues) are addressed minimally, since the program theory views the client's central problem as economic and social disadvantage. While the director acknowledged the necessity to address mental health needs after the housing placement, these concerns are clearly secondary. Although there have been no formal outside evaluation studies of the UCS program, the director cites impressive statistics: 95 percent of clients remain in residential placement for at least six months and 80 percent for longer than 18 months.

Program 2: The Living Place (TLP)

The Living Place (TLP) is a private, non-profit agency located in a large eastern city. It has been working with the chronic mentally ill for more than 40 years. Its program for the homeless mentally ill was begun in 1983 and includes the following components:

1. Outreach to the street-dwelling homeless, and those in municipally- and privately-operated shelters and drop-in programs.

2. A specialized milieu treatment program in which clients participate at the agency while still residing in the streets or shelters. The program prepares clients for the transition to agency housing.

3. Specialized housing, both transitional and permanent.

4. Agency-provided mental health, health, vocational, educational and socialization services and specialized treatment services for clients with co-occurring substance abuse, HIV infection or criminal justice histories.

TLP View of the Client

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Interviews with the Director of Homeless Services revealed that the TLP Homeless Program views its client's fundamental problem as "psychological estrangement." This estrangement, symbolized by a lack of family and friendship attachments, is believed to be the consequence of the client's mental illness (and any co-occurring substance abuse). Although the client's mental illness is understood to be not curable, it is "treatable" by addressing its "effects" (psychiatric symptoms, social and economic disadvantage and, above all, psychological isolation). The client's homelessness is viewed as emblematic of the loss of attachments to family, friends, the world of work, etc. This "social estrangement" is the central characteristic of the client that the program seeks to address.

TLP Theories of Help

The explicit theory of help, then, suggests that client "change" (the overcoming of estrangement and re-establishment of meaningful social ties) can best be achieved through participation in a therapeutic milieu or "community." The program views the regaining of "attachments" within the therapeutic community as the necessary prerequisite to rehabilitation and the possibility of productive, independent living. Implicitly, the theory of help draws from two major sources: ego psychology and the theory of therapeutic community.

Erikson's (1968) ego psychology suggests the possibility of continual psychological growth throughout the life span and, when combined with White's (1959) notion of an innate human drive for competency, forms the basis of TLP's explicit theory of help. Jones (1973) and Filstead and Rossi (1973) conceptualized the therapeutic

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community as the mechanism through which the mentally ill and others with disabilities could achieve individual growth.

The explicit and implicit theories of help, then, are primarily optimistic. They view the client's mental illness as highly significant but suggest that its most serious effects can be overcome through participation in a positive community experience that promotes psychological growth and development and sets the stage for acquiring the skills needed to live productively and with maximum possible independence in the community at large. The implicit theory of help suggests that the "psychological work" (regaining meaningful attachments and relationships) must be accomplished first, before the provision of such concrete services as housing or vocational training, to form a solid psychological foundation. In the absence of such a foundation, according to TLP's theory, clients will not have the "psychological stability" to use concrete services well. Once clients have achieved the prerequisite psychological stability, they are viewed as "ready" for rehabilitation.

TLP Services and Episode of Service

The scope of services, then, moves from the early, essential provision of "psychological" intervention to the provision of a range of rehabilitative services. The initial "low demand" holding environment provides the opportunity for "social estrangement" to be addressed. At the concrete service level, clients are offered: assistance in obtaining benefits (income, medical); housing (which is designed around a therapeutic community milieu model); mental health services (individual and group therapy, medication); health care services (primary care physician and nurses); vocational

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training, including placement in competitive employment; education (basic literacy, GED preparation, college-level studies); daily living and social skills training; socialization and recreational activities; and substance abuse treatment services (individual and group therapy, AA/NA, Double Trouble).

In describing the episode of service, staff highlight the major change which occurred in developing the program's theory of help. When first launched in 1983, the program moved quickly to house clients referred from shelters with the idea that after a quick housing transition clients would participate in the other services offered by the agency. However, of the first 20 clients to move from the shelter to TLP housing, only two remained in the program after a 90-day period. Eighteen either "disappeared," were hospitalized or discharged themselves. Following this experience TLP staff reconceptualized the program along the lines described above, stressing the need for clients to recreate "attachments" and "community," as a pre-requisite to rehabilitation. The episode of service was redesigned as follows:

Phase I: Shelter staff or TLP street outreach workers and TLP homeless staff identify potential clients. The clients, still residing in the shelter or street, attend a milieu treatment program five days a week (TLP vans provide transportation between shelters and the program). The low-demand milieu treatment program is the primary attachment opportunity. There is basic socialization, stressing bonding between clients and staff and to a lesser degree among clients. Activities include sharing meals, crafts, planning for and celebrating holidays and birthdays, going on trips and outings. There is no formal initial psychiatric assessment and no required verbal therapy or psychotropic medication

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(of course those on medication at the time of the referral are encouraged to maintain compliance). The program atmosphere is informal, relaxed and supportive.

In addition to its primary socializing function, participation in the milieu program provides an essential mutual assessment period for the program staff and clients to determine the appropriateness of the "fit" between them. During this phase, staff will begin to address the client's self-identified concrete service needs, including income and medical benefits, criminal justice problems and medical problems. Help in these and other client-identified is offered, although the client is usually not required to use it.

Phase 2: Housing is offered to the client at the point at which staff believe the client is sufficiently "psychologically" prepared to make a successful transition. Upon moving to a TLP supervised residence (with 24-hour staffing), the client joins an ongoing therapeutic community. Usually, the client will remain in the homeless milieu treatment program for a number of weeks or even months after the housing transition to maintain continuity of support and the crucial relationships established during Phase I.

Phase 3: Clients are reassigned to a "regular" TLP day program unit. Their individual goals (residential, social, educational, vocational) are formulated with their unit director. The full range of TLP services is available to the client. The residence becomes the primary attachment group.

Since work with clients at TLP is open-ended, episode of service terminations occur in a variety of ways: clients may be discharged from housing "for cause" but continue to participate in other TLP services; clients may move to less supervised TLP

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housing, to its "graduate" housing program or other independent housing; or clients may require a higher level of care such as long-term hospitalization.

In summary, TLP places emphasis on overcoming the "psychological estrangement" of its clients by offering them an opportunity to reformulate positive attachments before housing or other concrete or rehabilitative services. Once "attached," clients receive intensive assistance with concrete needs and opportunities to participate in a comprehensive rehabilitation program. As was true of UCS, there have been no outside formal evaluation studies of the TLP homeless program. The program's director reports a very high rate of success (over 90% of housed clients are able to maintain housing for more than a year). The director also described a number of clients who have obtained competitive employment and/or moved to independent housing. These reports, however, are purely anecdotal.

Program 3: Project Hope (PH)

Project Hope (PH) is a municipally-sponsored and operated program for homeless persons in a large West Coast city. It was begun in 1979 by the county mental health department and provides:

1. An outpatient/triage mental health services program, including assessment, crisis intervention and involuntary hospitalization, psychotropic medication and short-term counseling.

2. A mobile psychiatric assessment team.

3. An outreach program through which staff maintain contacts with some clients off-site.

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4. Referral to contracted housing services, either short-term (up to 30 days) or transitional (up to two years).

5. A socialization program, including both low-demand and structured group activities.

6. A money management program to assist client in budgeting effectively.

PH View of the Client

Although PH expresses its mission in a general way as "addressing the multitude of needs (emphasis added) of the severely mentally ill homeless client" (PH Program Description, 1993), its operational view of the client is a narrow one. Based on a series of interview with the Program Coordinator (PH Coordinator, 1994), the program clearly views its clients above all else as "psychiatrically impaired." The program coordinator believes that in the absence of psychiatric stability, all other service efforts will be unsuccessful. The program's clients, homeless and transient men over the age of 18 with DSM III diagnoses of major mental illness, are viewed as being primarily in need of stabilizing and ongoing psychiatric (medication) services.

PH Theories of Help

The explicit theory of help, then, views the client as having long-term psychiatric "illness," based upon an implicit medical model perspective. The theory suggests that not only must psychiatric stabilization be achieved first, but that it remain the central focus of the program. Other client needs (for structured program, housing, money management) are addressed within the program, but clearly as secondary to psychiatric treatment. While it is easy to critique this medical model view and its narrow implicit theory of help

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with its emphasis on psychotropic medication, it is important to place this approach in historical perspective to appreciate its positive aspects.

Until the early 19th century, mental illness in the United States was defined as demonic possession and those who suffered from it were chained and confined to prisons with criminals (Gallagher, 1987). Beginning in the early 1800s, under the leadership of Dorothea Dix, the European "moral treatment" model was introduced to the United States. Its crusade for asylums and "therapeutic treatment" ultimately led to the "reframing" of mental illness as "an illness like any other" (Smith, 1966, p. 103).

After World War II, mental illness achieved the status of a <u>public health problem</u> (Connery, 1968) with a new "non-stigmatizing" understanding of its widespread incidence in the general population and a public policy commitment to address it through federally- and state-funded community mental health programs. These programs were to be designed to undo the horrendous institutional conditions created in Dix's name and to establish a community-based service system, a goal that was never fully achieved. Beginning in the mid-1960s, under the policy of "deinstitutionalization," state after state discharged large number of patients from their facilities in the name of community mental health, but with grossly insufficient resources in the community to serve them.

The critique of the medical model approach is based on its structural components: "sick" patients on the one hand, with physicians or other helpers in an authority position on the other. The critique focuses both on the location of the problem within the individual, rather than in broader social conditions and on "the cure" consisting of the

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"treatment" of the sick individual (see Ehrenreich and Ehrenreich, 1974; Ehrenreich and Ehrenreich, 1975; Kunnes, 1972; Navarro, 1977; Ralph, 1983).

The PH program is located in a state that implemented the policy of deinstitutionalization in the 1970s without making adequate provisions for those discharged. According to the PH program coordinator, during the 1980s there were further reductions in services for both discharged patients and the mentally ill in the community. He attributed a large part of the homeless problem in his city to the large number of mentally ill persons who lack adequate housing and support services.

In this context, PH's efforts are focused on stabilizing the functioning of the homeless mentally ill through the provision of psychiatric services. Recent budgetary cutbacks have resulted in PH developing an even more narrow psychiatric focus, when many social work and paraprofessional case manager positions were eliminated. It is significant that in coping with budget reductions, the program protected its core psychiatric services while cutting back advocacy and case management. This reflects PH's explicit and implicit theories of help and the centrality of the medical model that underlies them.

PH Services and Episode of Service

PH serves an unduplicated count of 800 clients annually. The primary service site is the outpatient mental health clinic. New clients (self-referred or referred by hospitals or other social service agencies) are screened at this site and a primary case manager is assigned. Psychiatric evaluation occurs immediately or within a few days.

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In keeping with the criteria of excellence discussed earlier, the program hours and procedures are flexible. No appointment is necessary for initial intake. Clients who miss scheduled appointments are seen when they appear at the program. Regrettably, funding cuts have forced reduced hours of service. The program is now available from 8:00 A.M. to 5:00 P.M. Monday through Friday and 8:00 A.M. to noon on Saturday.

The outreach program, through which staff work with clients who are unable to come to the clinic, has also been reduced, although a small number of off-site visits are still made. The mobile psychiatric team is available "after hours" for crisis assessment and is designated to hospitalize patients involuntarily, if necessary.

Once enrolled in the clinic program, the primary case manager may make housing referrals (to municipally-contracted short-term or transitional housing) and, if the client desires, a referral can be made to the socialization program. The money management program, in which PH becomes the representative payee of government income checks and works with clients on budgeting, is purely voluntary and was created in response to client requests for such a program.

Thus, the typical episode of service is initiated through contact with the clinic program in which the primary psychiatric services are offered and through which other services may be obtained by referral. As was the case in the TLP program, the episode of service ends when the client moves or drops out, is discharged for non-compliance (a rare occurrence), or is placed in long-term hospitalization.

In view of its open-ended work with clients, it is surprising that PH has not developed a vocational component in its program. In all major studies that have asked,

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the homeless consistently state a preference to have concrete service needs met first (housing, employment) before mental health services (see Barrow and Lovell, 1983; Barrow, Hellman, et al. 1989; Plapinger, et al. 1988). The program coordinator characterized the clients as low-functioning and not good candidates for vocational rehabilitation. This characterization is consistent with the program's explicit and implicit theories of help, although it stands in clear contrast to both other programs studied, which have either provided vocational rehabilitation services directly (TLP) or regularly referred client to such services (UCS).

To summarize, the PH view of the client focuses largely on his or her psychiatric symptoms and functioning. In keeping with this view, the program's implicit theory of help (the medical model) revolves around the provision of psychiatric services, especially medication. On the explicit level, the program has been designed with as much flexibility as possible, to offer services that clients will readily accept. The clinic has a non-institutional, comfortable look and informality of service is the norm rather than the exception. In speaking with the program coordinator, however, one has the strong impression that the program's view of the client and its theories of help may have limited its horizons as much as its budgetary problems.

As was the case with UCS and TLP, there have been no formal outside evaluations of the PH program. Beyond some general demographic data on clients, the coordinator was not able to cite any outcome data.

Comparisons and Conclusions

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The analytical framework developed for this study has enabled us to explore a number of essential aspects of the identified "excellent" programs. Each program has embedded in it a view of the client and client's problem and the means through which clients are expected to achieved favorable "change" (theories of help). The "processing of the client occurs through the "episode of service," the longitudinal element of the client's participation in the program. The episode of service breaks down into a number of milestones or service segments that can be analyzed and evaluated separately.

All three programs claim to work with the identical client (homeless mentally ill adults with major DSM III diagnoses and functional disabilities). It is, however, an empirical question as to whether the programs are serving the same kind of client. This is an important question for comparative research that lies outside the scope of this study.

At face value, we have seen that the three programs have very different views of the client, alternatively as victims of social and economic system failure (UCS), as psychologically estranged (TLP) and as psychiatrically impaired (PH). In each case the view of the client is at the core of the program's theory of help, one focusing singularly on obtaining housing (UCS), the second offering clients an opportunity to reformulate attachments and community to promote personal development (TLP) and the third focused on achieving and maintaining psychiatric stability (PH). It should also be noted that of the three agencies, only UCS' underlying theories impel it to be involved not just at the level of individual client intervention, but also at the community level, as consultants in the development of homeless housing and as monitor of the use of homeless housing resources. Clearly, UCS' basic theory of understanding homelessness

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as a socioeconomic phenomenon impels its activities, in part, to the more macro community level.

In terms of services and episode of service there is some convergence among the three programs. While extensive empirical research would be required to draw specific conclusions about the degree of convergence, the author believes that, in general, the day-to-day work with these clients may be more similar than different. All three programs must address the psychiatric functioning of the clients (emphasized by PH), as well as their intensive service needs for entitlements and housing.

For example, the Director of UCS, the most non-clinically oriented of the three programs, acknowledged that such services as case management, substance abuse treatment, psychotropic medication services and mental health counseling are important in helping clients maintain housing once it is achieved. Clearly, however, these services have a different meaning to him and his agency culture than they might have in the other two programs, where individual psychological and psychiatric interventions assume greater importance.

It should also be noted that the exploration of the three programs under study was based on interviews of program directors only. It was beyond the scope of the study to document either lower level staff or client behaviors and attitudes, the understanding of which is essential to developing knowledge about any program.

For more than a dozen years beginning in the early 1980s, while the debate about the nature of homelessness in the United States has unfolded, public policy makers have been under increased pressure to respond to the problem. The three programs reviewed in

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this chapter were "first generation" responses. As we have seen. each program's view of the client and underlying theories of help set the boundaries of its mission and scope of services. We have also seen that it is useful to conceptualize what happens to clients in programs over time (the episode of service) in order to be able to study outcomes and achievement of program goals. We turn now to the study of client outcomes in greater depth.

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CHAPTER 3

Preliminary Methodological Considerations

In developing an evaluation study of client outcomes in social programs, one is immediately confronted with the complexities of the current debate about social work's research paradigm. The debate centers as much on fundamental questions about the nature of reality and human interaction as it does on the appropriate methods for understanding them. Saleeby (1989) suggests that a rift between "knowing" and "doing" has occurred within social work, attributable to the persistent attempt to utilize the "positivist" research paradigm that devalues "doing" in general and estranges it from its most important potential source of energy: "respect for, interest in and positive identifications with the natural world" (p. 558). Hartman (1992) sees the same tyranny in the "subjugation" of "local, popular, indigenous knowledge" to the research-bound "unitary" knowledge of the positivist paradigm. Although on reflection Hartman is clearly creating a false dichotomy between two "kinds" of knowledge (after all, knowledge is knowledge, no matter how or "where" it is generated), still her caution and Saleeby's concerns represent major areas of unrest in the discussion of the social work research paradigm.

The debate between the "positivist" and "heuristic" approaches to the development of social work knowledge (see Heineman-Piper, 1989; Tyson, 1992; Reid and Smith, 1989, 1981) raises important questions for the proposed client outcome study.

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The selection of a theoretical approach and specific method will reflect the author's position within the debate.

Guba (1990) has offered a useful typology that captures the essence of the paradigm debate. He identifies three contenders to the throne once so securely held by the positivist inheritors of Descartes' assertion that "certain knowledge" exists and that "objective" methods can be used to obtain it.

The first emerging paradigm identified by Guba is post-positivism, which, in terms of ontology, replaces the idea of a simple, objectively knowable world with the concept of critical realism, which suggests that while objective reality exists, it is impossible for imperfect humans to comprehend it correctly.

Epistemologically, then, the pursuit of knowledge of the world assumes a modified objectivist stance in which researcher objectivity remains an ideal that can be striven for but only approximated. The critical community plays an essential role here by providing the necessary objectivist "corrective." Methodologically, post-positivists emphasize critical multiplism, conducting inquiry more naturalistically than their positivist forbearers, using qualitative as well as quantitative methods and acknowledging the importance of (inductively derived) discovery, as well as the testing of deductive theory, in the process of inquiry.

Guba identifies critical theory as the second emerging paradigm. It encompasses "ideologically oriented" inquiry, including Marxist and neo-Marxist, feminist and "ethnocentric" approaches. Here, Guba identifies a paradox between the critical realist ontology that grants the existence of an objective reality and its heavily subjective

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epistemology that views all inquiry and knowledge as "value-mediated." To those who adopt this stance, the purpose of inquiry is to eliminate the <u>false consciousness</u> of reality by (methodologically) applying the

concepts of critical theory to discover "truth." Hence, there is a significant disjunction between an objectivist ontology and a highly subjective epistemology and methodology.

Guba identifies <u>constructivism</u> as the third emerging paradigm. Here, reality itself is seen as relativist (the ontology). Facts and theories are viewed as subjective and value-laden and there is no ultimate method for determining truth or falsity. Knowledge, then, is merely a set of <u>constructions</u> or models of a subjectively understood reality. The relativist ontology and subjective epistemology are complemented by a methodology that incorporates both hermeneutics (describing constructions as accurately as possible) and dialectics (comparing and contrasting constructions critically so that they must "come to terms" with one another). Knowledge is local and relative, generated through a subjective process in which inquirer and subject are fused, using methods that promote intersubjective consensus.

All evaluation studies, including client outcome studies, must confront the issues raised by Guba's paradigm debate. As we think about evaluation, a number of models or approaches (in Guba's term, <u>constructions</u>) vie for our attention. For beyond simply categorizing client outcomes (as positive or negative, for example), which is a descriptive concern, we will want to understand the processes and dynamics that shape specific outcomes so that practice can be improved (analytical concerns). Thus, we will want to identify the dynamics that produce differential outcomes. In approaching this task, the

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author's methodological thinking will be informed by Guba's constructivist paradigm ideas.

Understanding Organizational Effectiveness

A good starting point to begin a consideration of the methodological issues involved in designing client outcome studies is to consider how organizational effectiveness has been conceptualized. For example, Etzioni (1960) offers a powerful theoretical construct -- the "systems model" -- to understand organizational dynamics and effectiveness. In contrast to the previous mainstream model (the "goal model"), which focused on the achievement of the organization's super-ordinate (or stated) goals, Etzioni's systems approach reconceptualized the term "organization" to mean "a working model of a social unit that is capable (emphasis added) of achieving a goal" (p. 261).

In this conceptualization, organizations are viewed as multi-functional units, as much concerned with their own integrity and maintenance (i.e., acquiring environmental resources and supports for internal stability) as with the achievement of super-ordinate goals. Since this means that 100 percent of resources can never be invested in achieving super-ordinate goals, a goal-focus will always find some quotient of organizational ineffectiveness.

Charles Glisson (1981) used Etzioni's (1960) "systems" approach to construct a model of organizational dynamics that he applies to social service organizations. In it, he identified four major sub-systems: Goals and Values (consisting of service objectives, ethics, ideologies and social traditions); Technology (the organization's knowledge base, techniques and skills); Structure (the division of labor, hierarchy of authority and pattern

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of participation in decision-making); and Psychosocial (the informal organization, social relationships among organizational actors, worker motivation and job satisfaction. A fifth sub-system, Management, has the major responsibility for selection and assignment of personnel, creating and manipulating structure, utilizing rewards/punishments/incentives and developing communications channels. Management is also responsible for managing the Environment, the agency's supra-system, which consists of social attitudes, funders and regulators, the professional community, community groups and clients.

Using Etzioni's (1960) and Glisson's (1981) systems ideas, we see that the search for understanding of effectiveness and outcomes in social programs is extremely complex. We must first specify what kind of effectiveness we are interested in ("production" -- super-ordinate goal achievement -- or "maintenance" – internal and/or external stability). The systems model also poses the question of whose perspective will be used to measure effectiveness: the clients? staff? agency administrators? government bureaucrats? elected officials?

When viewing organizational effectiveness solely through the lens of super-ordinate goal achievement the primary focus in organizational effectiveness or client outcome studies tends to narrow to an exploration of client characteristics and interactions. Indeed, most outcome studies of programs for the homeless mentally ill, the subject of this dissertation, analyze differential outcomes (i.e., dropout, rehospitalization, resumed homelessness, move to stable independent living) -- the dependent variables -- in

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terms of selected client characteristics (i.e., diagnosis, program compliance, client history and the like) -- the independent variables.

Using the systems model, on the other hand, the understanding of differential client outcome would be explored through a wider lens encompassing a larger number of factors, from general social attitudes towards the homeless, to funding and resource limitations, level of political support, agency structure and leadership. Thus, in analyzing super-ordinate goal attainment using the systems model, the task is complicated by the presence of a large number of variables and the need to order them analytically to understand their individual and additive effects on differential client outcomes.

Guba's constructivist point about multiple realities seems to be supported by this line of thought. Social programs do reflect multiple realities, none of which can probably claim the status of ultimate truth. We can even grant that the "true" reality may lie beyond our abilities of comprehension. To the constructivist, this is not an expression of despair, but simply the ultimate ontological statement that informs the quest for intersubjective consensus. We turn now to a number of theoretical approaches that can be used to design the study of differential client outcomes in programs for the mentally ill homeless.

Differential Program Evaluation

At its most basic level, our interest in client outcomes is concerned with program improvement. That is, we want to analyze outcomes to develop an understanding of them so that a program can be modified to improve them. This concern for individual program

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improvement (formative research) rather than the production of generalizable knowledge across programs (summative research) has been a central focus of evaluation research in social work for some time (Tripodi, Fellin and Epstein, 1978; Epstein and Tripodi, 1977; Weiss, 1972). Since our focus is improvement, our interest goes beyond the level of a descriptive study per se. We are attempting to construct an analytical (causative) model encompassing both the identification of the variables involved in differential outcome and the relationship among them.

In developing research whose primary purpose is to capture an understanding of program dynamics that will inform program practice for improvement, Epstein (1993) suggests that social workers might utilize a number of epistemological approaches, including a model of differential program evaluation, grounded theory, the application of social science theory and constructs and the use of research analogues drawn from practice. Research design, then, is an iterative process in which the "reflective" practitioner/researcher (Schon, 1983) moves back and forth among a range of epistemological possibilities.

Let us consider the application of Epstein's differential program evaluation model (DPE) to study client outcomes in a program for mentally ill homeless. At the heart of the DPE model is an assumption that social programs naturally produce a wealth of information that can be used as the basis for improvement-driven research. This is a "practitioner-friendly" model in that it does not require the imposition of the classical experimental design, with its technical and ethical problems, but views practice and research analogously as "information-driven, problem-solving processes" (Seigel, 1984).

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The researcher, then, uses existing program data to apply experimental logic in place of classical experimentation.

This approach could be used to construct a research design of differential client outcomes, using existing MIS data, in the following way:

1. Construct a profile of all clients who were in the program for a specified time period (demographic data such as gender, diagnoses, history of homelessness, psychiatric hospitalization history, vocational history, etc. and program participation data, including compliance, level of participation, etc.)

2. Compile a list of all discharges that occurred over the period.

3. Create a typology of discharges, based on: 1) discharge valence, positive (e.g., "graduation" to more independence) or negative (drop-out, discharge "for cause" such as rule-breaking or non-compliance); 2) whether discharge occurred abruptly or came about over a longer period of time; and who initiated the discharge (i.e., client, staff or other).

4. Create a typology of "continued stay" clients, those who are not discharged but remain in the program throughout the period, based on their characteristics (again both demographic and program participation data). Once compiled, this data could be analyzed to construct profiles of clients in various categories (positive discharged, negative discharged, continued stays) and comparisons among categories to determine if there are unique characteristics within groups based on the variables studied.

In conducting such a study, the researcher would hopefully be able to determine what client characteristics are associated with differential outcomes (positive or negative discharge or continued stay). Epistemologically, the researcher's personal knowledge or

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experiences (what qualitative researchers refer to as "retrospective reconstructions") are incorporated into a theoretical model that identifies purported key variables: the client's personal characteristics, diagnosis, history, etc. and level of program participation and compliance. The ontological assumption here is that the variables identified by the researcher (based on previous knowledge or experience) are saliently related to differential client outcomes. DPE makes the additional epistemological assumption that ordinarily-generated program data often contain much of the information needed to test the researcher's theories.

In our example, the study design assumes that the explanatory variables that account for differential outcome are client characteristics and levels and quality of client participation. While it is true that the data can be generated from existing regularly compiled chart information, it does not follow logically that they are indeed the key variables that account for differential outcomes.

The DPE model, then, gives great importance to the researcher's knowledge of the program. In the context of the "paradigm debate" and Guba's taxonomy, DPE is an example of the constructivist at work, building a model of program dynamics. It is therefore more closely related to an inductive grounded-theory approach than one might initially assume. The general point is that while there are clearly many other variables that could be brought into play -- staff structure and characteristics, government regulations and oversight, etc. -- the researcher who is familiar with the program develops a theoretical model based on that knowledge to identify the salient variables as a starting point.

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One of the strengths of the DPE model is its focus on program modification and improvement as a means of testing the validity of research findings. For example. let us assume that a study based on the design outlined above found that a large portion of negative discharges resulted from clients using illegal drugs. The program might then be modified to either address this problem by developing a new component or. if this were not possible or if it were attempted and failed. then new admission criteria could be implemented to exclude drug users. In these ways. the negative discharge rate would hopefully be decreased and the research findings validated in an iterative process of program modifications.

Thus. consistent with Guba's constructivism paradigm, the DPE model views the researcher's knowledge of program "reality" as a subjective matter. albeit well-informed. Analogous to Guba's formulation of validity emerging from constructs that must "critically come to terms with each other," the DPE model views the theories constructed and tested by the researcher as receiving their ultimate test through the process of program redesign and improvement.

The Inductive Approach and Grounded Theory

A second general approach to understanding differential client outcomes in social programs is illustrated by the works of Goffman (1961) and Polsky (1962) in their portrayals of the lives of psychiatric patients in mental hospitals and disturbed adolescents in residential treatment respectively. These two studies directly relate to our interest in client outcomes since they are both concerned with the natural history or career of clients in their respective programs. In their approach. Goffman and Polsky sought.

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through an inductive process, to document and then develop relevant grounded theories (Glaser and Strauss, 1967) to explain client outcomes. Most studies of this type use qualitative methods, particularly ethnography, to document the subjects' world as carefully as possible, from the subjects' perspective. The research does not impose predetermined theories or concepts. Understanding of the subject's world emerges from extensive participant-observation or in-depth interviewing and from the generated grounded theory that emerges from the inductive process.

This approach to research clearly reflects strong ontological and epistemological beliefs. Ontologically, the approach represents the belief in the subjectivity of human experience (in Guba's [1989] terms, "the value-ladenness of facts and experience"), while epistemologically it recognizes that if the researcher is to gain significant knowledge, he or she must shed the impossible stance of objectivity outside the subject and enter into the subject's world. A crucial epistemological assertion of the ethnographic approach to inductive inquiry is that simply entering the subject's world is not enough. The researcher must be committed to understanding the subject's world from the subject's point of view.

The literature reviewed in Chapter 1 of this study illustrates the point. While virtually all studies were designed to meet the homeless in their natural environments (i.e., shelters, streets, other marginal living places), we have seen how simply applying pre-determined psychiatric diagnostic criteria or symptom assessment scales led to the classification of large numbers of the homeless as "mentally ill." However, when a subject's behaviors were viewed from his or her perspective, such characteristics as being disheveled or wearing many layers of clothing were not seen as aberrant "symptoms" but

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rather as reflections of the cultural norms of homelessness. With this critique in mind, we shall briefly review Goffman's and Polsky's studies and discuss their application to client outcome studies.

Employing participant observation, Goffman (1961) was able to trace the career of psychiatric hospital patients through three stages: pre-patient phase (the "home world"), inpatient phase (the "institutional world") and the ex-patient phase. In following the patient career, Goffman reached the central conclusion that not only does the institution regulate the patient's routines and rigidly structure the patient's external world, but that it also fundamentally shapes the patient's internal world (his or her definition of self).

The transition from "home" to "institutional" world involves an intricate process of dispossession in which the patient is "stripped" of previous roles, material possessions, rights and responsibilities and autonomies of self. This process is quickly followed by a period of "mortification of self," through "obedience testing," "will-breaking," forced deference and rigid regimentation. It is the institution's formal and informal privilege system that provides the major adaptive mechanism, in the reorganization of the self that follows. Secondary adaptations such as "knowing the ropes," "using the system" or "playing it cool" offer some possibility of "personal efficacy," but Goffman found that the vast majority of patient effort was expended in primary adjustments to institutional demands ("going along," "institutional withdrawal"). Thus, the major grounded theory developed by Goffman is the "moral career" of the patient, which constitutes his or her

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core beliefs about self and others. The documentation of the institutional system and its role demands in modifying and shaping the moral career was a core finding of the study.

Polsky (1962) used the same method of participant-observation to understand client careers (outcomes) in a residential treatment program for emotionally disturbed adolescents. The research grew out of the recognition that client outcomes could not be understood simply as being related to the provision of high quality clinical services. Despite the fact that the program had gathered a highly skilled staff of clinicians, many clients made little or no progress in achieving insight or changing negative behavior patterns.

Polsky's contribution was to direct attention away from the focus on clinical services to the "milieu" in which they existed -- the social world of the facility and the clients' experience of that world. In doing so, he used an inductive method to uncover a social structure and system that was often at odds with the therapeutic intent of the program and that powerfully shaped the clients' experiences in an often anti-therapeutic way.

At the heart of Polsky's work was the identification of a powerful "delinquent" sub-culture among clients (and a number of cliques, sub-groups and interactive patterns), that proved to be better predictors of individual outcomes than the quantity or quality of the program's clinical services. Polsky found that the dynamics of the client social system were much more powerful in shaping clients' behaviors than identification with the staff's values and therapeutic goals. He concluded that "an analysis of the social and cultural process in a given institution is a basic requirement for any intelligent planning

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for the development of a therapeutic milieu" (p. 7). Such an analysis, it must be added, is also essential in understanding differential client outcomes in social programs.

The application of Goffman's and Polsky's inductive inquiry techniques and findings to the study of outcomes in other social programs represents the iterative epistemological process described by Epstein (1993) and Bernstein, Goodman and Epstein (1992). For, example, the theory inductively developed by Goffman or Polsky might now be applied as a deductive model to inform the study of differential client outcomes in other programs. Thus, there is the possibility of a blending of social science theory (concepts derived by Goffman or Polsky) and inductive discovery to generate new grounded theory.

The Use of Deductive Social Science Theory

Another approach to the study of client outcomes involves the application of deductive social science theory. To illustrate, we will use a concept closely related to Goffman's notion of client career (and thus related to our own interest in differential client outcomes): the concept of "career contingency" developed by Hasenfeld (1983). The definition of this theory is quite simple: what happens to clients in programs is based less on their level of need than on the attribution of "social worth" that staff assigns to each client.

Hasenfeld's theory is based on the central elements of exchange theory (Homans, 1958). According to Homans, all human interaction can be viewed as an exchange of goods, both material and non-material. Exchanges are based on the human quality of "needs." Some need is based on a simple division of labor or scarcity; some is more

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psychological. In every exchange there are costs (monetary, necessity for concerted effort, the lost values of pursuing an alternate course of action, etc.) and rewards (material, psychological). The "profit" in the exchange equals reward minus cost. An important corollary to exchange theory is Gouldner's (1960) "universal" norm of reciprocity: people should help those who have helped them and should not injure those who have helped them.

Hasenfeld's career contingency theory sees the interaction between clients and staff in exchange terms. Through social interaction between staff and clients a process of "typification" occurs in which each client is categorized as to his or her "social worth." Hasenfeld suggests that this is usually based on the client's personal characteristics (social class, race, gender, etc.). The intensity and quality of services that the client receives is based on his or her "social worth" status, which largely determines client outcome.

Hasenfeld then goes on to complicate matters, however, adding to his elegant concept of social worth a number of other factors that contribute to career contingency: 1) the power differential between staff and clients (again expressed in terms of exchange theory as the ability of clients to capitalize on their "social worth" to obtain services); 2) the cultural and normative context of the organization and its staff; and 3) the political and economic needs of the organization and staff.

With the addition of these new factors, the theory is not nearly as straightforward and testable as a hypothesis. Now the theory directs us simultaneously to both microsocial processes within the program and more macro organizational matters, similar to Etzioni's organizational model discussed above. Beyond this complication, there are

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two other major problems in applying the theory. First, Hasenfeld does not address the dynamics among the identified elements. We don't know, for example, if "social worth" of a clients is more salient to outcome that the normative context of practice or the organization's political and economic needs (although we grant that social worth can subsume these elements). In the absence of a dynamic model that weights the factors, at least in a theoretical way, the ontological underpinnings of the theory are compromised: how do we know all the factors are included or that an included factor is not extraneous?

Secondly, there is the problem of operationalizing the theoretical concepts and measuring them. This would involve the very complex task of defining terms like "power," "cultural and normative context," "political and economic organizational needs" and measuring them in the program setting.

While these problems are formidable, still the application of Hasenfeld's contingency theory has a strong appeal. The concept of client "social worth" is particularly compelling in shedding light on staff/client interactions and client outcomes. Understanding the "typification process" through which staff assigns each client a social worth status and tracing the resulting process of staff/client interactions might yield a significant understanding of differential client outcomes.

A similar application of deductive social science theory to the study of differential client outcomes in social programs was developed by Etzioni (1973) in response to developments in the reform and study of mental hospitals. With the advent of deinstitutionalization and the innovations that attempted to transform the total institutions

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that Goffman described into therapeutic communities, a dialogue developed regarding the study of such settings and differential client outcomes in them.

By the early 1960s, the functions of the mental hospital identified earlier by Parsons (1957) (custody, protection, socialization and therapy) were rhetorically rejected and the concept of the therapeutic community (Jones, 1973) was substituted. In this formulation, the social structure of the hospital, reflecting the primacy of the therapeutic milieu, was to be transformed along the following lines: 1) the assumption of an active rather than passive patient role; 2) the elimination of the "two-class" system between staff and patients (egalitarianism); 3) the elimination of professional roles and primary role identities; 4) the establishment of open communications between patients and staff; and 5) the redesign of the program to resemble the "real world" as much as possible so that the patient can "learn" and "practice" the skills needed to return to the community (Filstead and Rossi, 1973).

In an important ontological and epistemological critique of this new approach, Etzioni (1973) cautioned against the application of industrial human relations theory to the conceptualization of mental hospitals (for an example of the human relations approach see Wessen, 1964). While acknowledging the attractiveness of this approach, which stresses communications and interpersonal relationships (consistent with the revitalized concept of therapeutic community), Etzioni suggested that key structural elements also have a significant impact on patient/staff relationships. His list of key variables includes some of Hasenfeld's items and adds some others: power structure and

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lines of authority; professional training and role identity; ideology; intra-organizational affiliations (i.e., union membership); and organizational resources (budget).

Again, as in the case of Hasenfeld, the deductive theory directs us to a broad range of factors to account for staff/patient interactions. Again, the factors are unweighted and their operationalization and measurement pose daunting challenges. The key concept here is that, in Etzioni's systems terms, the patient/staff relationship and its impact on patient outcomes, reflect important structurally sensitive factors that must be taken into account.

Compliance Theory

Etzioni's (1975) more refined attempt to capture an understanding of organizational dynamics is found in his compliance theory, which offers a third possible application of deductive theory to understanding outcomes in social programs. Compliance theory focuses on the organizational equivalent of social order. In it, Etzioni reasons that it is *stability* in the reciprocal relationships between the organization (as reflected in its exercise of power) and its "lower level participants" (i.e., clients) that is needed above all else to assure the overall stability of the organization. While adherents of Guba's critical theory paradigm would be quick to identify a conservative bias in Etzioni's theory (it is easy to assume that a description of the conditions needed for organizational stability might reflect a preference for such stability), he has nonetheless constructed an elegant model of organizational dynamics.

To begin with, compliance theory (Etzioni, 1975) suggests that organizations typically employ one of three primary methods or styles of power to gain compliance

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from "lower level participants" (lower-level staff or clients): 1) coercive power (the threat of physical sanctions or deprivation of basic needs); 2) remunerative power (the control of material resources); or 3) normative power (the allocation of symbolic rewards, deprivations, esteem, prestige). Similarly, lower-level participants typically display one of three kinds of orientation or "involvement" in their relationship to the exercise of power by the organization: 1) alienative involvement (an intensely negative orientation); 2) calculative involvement (low intensity positive or negative); or moral involvement (highly positive and committed involvement based on shared values or referrent identification with the organization as "superior").

The compliance matrix (Figure 1 below) suggests that organizations in categories 1, 5 and 9 in which there is congruence between power style and involvement, will be the most stable and hence most common. Organizations in other categories are expected at the least to be inefficient and are most likely to be unstable.

Figure 1. Etzioni's (1975, p. 12) Compliance Matrix

Kinds of Power:	**Kinds of Involvement:**		
	Alienative	Calculative	Moral
Coercive	1	2	3
Renumerative	4	5	6
Normative	7	8	9

With Figure 1 in mind, let us consider how compliance theory could be used to understand client outcomes in social programs. The question the matrix poses is: what kind of power is exercised in the program and what kind of involvement do its clients

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reveal? The model assumes that coercive power is most likely to result in client alienation and intensely negative involvement. A renumerative power style would be expected to result in low-intensity, calculative client involvement, while a normative power style would lead clients to an intensely positive moral commitment to the program. It might be possible to track the impact of these reciprocal relationships on client outcomes.

Reflecting on Goffman's (1961) work discussed earlier, for example, the mental hospital he studied clearly represents the type #1 organization in Etzioni's matrix in which coercive power and alienative involvement were the rule for most clients. The "secondary" adaptations that Goffman described were examples of calculative or even moral involvement, acknowledged by Goffman to be atypical. Certainly, the use of compliance theory can shed significant light on client/staff and client/institutional relationships.

However, compliance theory also raises the important question of the relationship between organizational types as identified by Etzioni and measures of program "success." If, as discussed in Chapter 2, the ultimate purpose of social programs is to assist clients in such a way that they become less dependent on services in the future (or, in the case of the severely disabled, become as independent as possible), then the achievement of less dependence will always to some degree be included in the definition of client "success." It is important to recognize, then, that Etzioni's matrix is concerned with organizational stability or success, not client outcomes or "success." Thus, a type # 1 social program

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(coercive power, alienative involvement) might be found to be extremely stable, but it would not fulfill the basic requirements of a "successful" program under our definition.

Applying compliance theory empirically in the study of social programs presents a further challenge. While Goffman demonstrated that the "client involvement" part of the equation is relatively accessible to empirical study, the question of the program's power style poses some complications. Here, it might be expected that staff and clients would have different interpretations of the sanction system. For example, in programs for the mentally ill, staff enforcement of psychotropic medications may be viewed by many clients as coercion, but may be seen by staff as a part of the program's normative commitment to stabilize and enhance client functioning. In the absence of agreement between clients and staff about how to rate specific sanction instances or patterns, a methodology would have to be developed to make an overall judgment. For example, a panel of judges might be used to assign such ratings. The problem with this approach is that even a high degree of inter-rater reliability might not (and probably would not) reflect how the organizational participants actually experience the sanction system.

We return then to difficult questions of ontology and epistemology. Guba's constructivist might ask whether Etzioni has gone too far in assuming that there is an objectively identifiable program reality that can be known "outside" the experience of staff and clients. From the perspective of Guba's paradigm dialogue, both the debate between the adherents of the therapeutic community (Jones et al) and the structuralists (Hasenfeld, Etzioni) and the problems of using Etzioni's compliance theory, highlight the ontological and epistemological problem associated with applying deductive theory.

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In the former debate, the therapeutic community approach viewed the mental hospital as a "closed" small society. The structuralists cautioned that environmental factors, both internal (power structure, subcultures, professional affiliations) and external (political, cultural, financial and other material supports) have a significant impact on program dynamics and outcomes. Epistemologically, then, the ontological assumptions of the given theory point to where to look to develop knowledge and understanding of the program. Following its ontology, the therapeutic community school looked to patterns of staff/patient communications (the primary process of the "closed" society model) to understand program outcomes. The structuralists, on the other hand, specified a range of factors, including but moving beyond communications, that must be considered if valid program knowledge is to be gained.

The deductive theorists, however, raise for us the issue of "objective" reality. In organizing theoretical concepts, they ultimately direct our attention to a set of variables deemed to be most salient. The problem here is both within the internal constructs themselves (in the Hasenfeld theory, for example, how does one weight the importance of client "social worth" vs. environmental demands) and in their application (i.e., in Etzioni's compliance theory, the divergent interpretations of the sanction system by staff and clients).

This is not to say that the deductive theoretical approaches discussed do not provide useful and provocative research ideas and strategies. One is tempted, however, to accept Guba's constructivist conceptualization in evaluating the worth of deductive theory in the study of client outcomes in social programs. The constructivist's epistemological

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approach, which embodies a descriptive, interpretive and dialectical process, seems best suited to the relativist ontology at the heart of how both staff and clients experience their participation in social programs.

Chapter Summary and Conclusions

This chapter has offered a preliminary exploration of a number of research approaches that might be used to study differential client outcomes in social programs. The review highlighted some of the important issues relating to the current debate concerning social work's research paradigm.

First, we considered differential program evaluation (DPE), an epistemological approach that assumes that program knowledge can be generated from available data for studies aimed at program improvement. This is a "practitioner-friendly" approach that does not require the imposition of classical experimental design that is often technically impractical or ethically undesirable. In maximizing the use of available data, neither the researcher nor program staff is burdened with additional data collection. Lastly, DPE is grounded in the experience of program participants who are most knowledgeable about the program and who are in the best position to implement modifications, a significant political advantage.

DPE is not an a-theoretical approach. The experientially-based process of "retroactive reconstruction" carried out by the researcher (or the program participants who familiarize the researcher with the subject of study) are really theories about how the program operates. Methodologically, these theories can be tested either quantitatively or qualitatively. While those who formulate the research will certainly have biases and

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subjective preferences (and their "reconstructions" may even be wildly off the mark), it is suggested that the DPE model has a kind of built-in validity mechanism: the "testing" of findings in the program modification/improvement process. Thus, supporters of DPE point to its pragmatic potential to inform the process of program improvement, in contrast to making lasting contributions to generalizeble knowledge.

We next considered the inductive/grounded theory approach to the study of client outcomes. Our exemplars were the works of Goffman and Polsky, who conducted qualitative ethnographic studies using the participant observation method to illuminate differential client "careers." Goffman's and Polsky's theories illustrated how the inductive method can be used to generate grounded theory to provide a rich understanding of client and staff experiences in programs. Inductive methods are well suited to capture both regularity and uniqueness in the experiences of subjects.

Goffman's grounded theoretical concept of "client career," for example, is a particularly useful construct in designing and conducting inductive studies of client outcomes. It alerts us both to the "natural history" approach to understanding the client experience and to the important role of the program in shaping the client's view of self. These inductively generated concepts can be used as deductive "categories of thought" in approaching a fresh study. Similarly, Polsky's finding of distinct client sub-cultures that either support or undermine the therapeutic intent of programs is a rich construct to be explored in comparable settings. The natural extension of this concept is to explore staff sub-cultures and expectations as well.

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Finally, we reviewed possible contributions of a deductive theoretical approach to the study of differential client outcomes. Two major advantages of using deductive theory were recognized: this is the kind of research best suited to developing generalizable knowledge and it is often a more "economical" approach than the other approaches discussed. The economy of the deductive approach lies in the way the theory narrows and directs the research effort, defining specific variables, eliminating the extraneous and often pointing directly to specific methods of data collection and analysis. This kind of economy contrasts with the inductive approach in which data collection is often quite labor-intensive and in which a great deal of data has to be "processed" in developing findings.

As we have seen, the strength of the deductive method -- the clear delineation of variables and their predicted relationships -- poses some problems in the context of the paradigm debate. Deductive theoretical models suggest both that "objective" reality exists and that it can be known through "objective" methods. Guba grants that post-positivists recognize that the ontological and epistemological ideal of objectivity can only be approached and never fully achieved. Still, as we saw in our examples of deductive theory (Hasenfeld's "career contingency" theory with its emphasis on staff attribution of client social worth, Etzioni's more structural approach and his "compliance theory"), this approach is much more consistent with the positivist's orientation.

After reviewing all of these approaches, in pursuing research on differential client outcomes in social programs, Guba's constructivist paradigm seems to offer the most satisfactory way of conceptualizing the problem. Ontologically, it assumes the relativist

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stance which grants that "reality" is perceived and experienced differently by those who participate (staff, clients). Epistemologically (consistent with Epstein's [1993] "iterative" approach described earlier), it suggests that knowledge development is also a subjective process that can draw from several of the approaches reviewed. The method of *critical comparison* that the constructivist paradigm invites, then, is the way to develop the intersubjective consensus yielding "knowledge" to inform social work practice.

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CHAPTER 4

Study Methodology, Research Issues, Program Setting

The Study Methodology

Drawing from the preliminary methodological discussion in Chapter 3, the researcher designed a study to understand client outcomes at Harlem House, a 24-bed residential program for mentally ill adults located in a large city in the Northeastern United States. The study, categorized as an applied research evaluation study, was designed to yield understanding that could lead to improved program practice (Patton, 1990, pp. 11-12). It drew on several of the research concepts discussed above, reflecting the iterative theoretical approach described by Bernstein, Goodman and Epstein (1993) and Epstein (1992). The methodology combined qualitative inductive inquiry and the building of grounded theory, with previously derived deductive theory (Hasenfeld) serving as an orienting concept for exploration.

Hasenfeld's theory -- the suggestion that clients' outcomes are related to their social worth rankings assigned by staff -- formed an important basis of inquiry, since it so clearly reflects the constructivist epistemological approach preferred by the investigator. Since the investigator believed that the independent variables identified as impacting on staff's attribution of client "social worth" in Hasenfeld's general theory were more or less arbitrarily identified without empirical evidence (i.e., social class, race, gender), the study of Harlem House was designed to use qualitative methods to empirically explore if, how and on what bases social worth is assigned to clients in the program and whether a "social worth pattern" could be identified that had a direct impact on client outcomes.

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Thus, the core question of the evaluation study of Harlem House was: how can we explain and understand differential client outcomes in a residential program for mentally ill homeless adults? The term *outcomes* was operationalized to include: "positive discharge" to more independent living, competitive employment, reuniting with family and the like; "negative discharge" in which clients lose the services and supports they need to function well in the community and may return to homelessness; or "continued stay" in which clients seem to remain in the program indefinitely. Thus, a key process in the program, the discharge process, was and central focus of the study.

The core question reflects an interest in:

1. **Program improvement:** Examining a critical process in the life of the residence to determine how it occurs and, by making it explicit and subject to self-examination, generating insights that might improve the program/process.

2. **Interrupting the cycle of homelessness:** On a policy level, since government has supported the creation of residential programs for the mentally ill homeless and since this policy envisions the creation of permanent and stable living environments, the "negative" discharge of clients has significant implications.

3. **Social work knowledge:** How can we as social workers understand client "careers" and outcomes as an essential process that occurs in every social program, reflecting its specific practice context and organizational culture.

The study falls into Patton's (1990) category of applied research since its purpose is "to inform action, enhance decision making and apply knowledge..." (p. 12) in the operation of Harlem House. According to Patton (1990):

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> Applied evaluation research is judged by its usefulness in making human actions and interventions more effective and by its practical utility to decision makers, policy makers and others who have a stake in efforts to improve the world (p. 12).

The study of client careers at Harlem House was based on three important qualitative research elements identified by Patton: 1) the study was oriented inductively toward exploration and discovery; 2) an effort was made to develop a holistic understanding of the client career process, rather than identifying discrete variables to be operationalized and statistically expressed, as in quantitative research; and 3) the researcher adopted the stance of <u>empathetic neutrality</u> to understand the world of Harlem House <u>as it is</u>, rather than seeking to prove a particular pre-determined theory. Thus, the researcher's work in conducting qualitative interviews combined the empathy for staff and clients needed to be able to understand their reality, with neutrality toward the findings of the study.

Because of limitations of time and expense, the researcher used open-ended in-depth interviews for this study. Although the researcher might have preferred to conduct more extensive participant-observation, this was not possible due to time constraints. The method employed in the study, open-ended interviews, were used to develop a detailed understanding of client careers and outcomes in the residence, as well as to explore the concept of "social worth," which would be expected to be reflected in the program's discharge pattern (negative and positive discharges), and how clients are singled out for long-term "continued stay" (i.e., those who are <u>not</u> discharged).

Discharges fall within the unit of analysis that Lofland and Lofland (1984) define as episodes. By definition, episodes are remarkable and dramatic events to participants;

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they are expected to provoke strong emotions. In the social life of Harlem House, discharges would be expected to have this quality, deeply affecting staff and clients. The circumstances of discharge, whether "negative" ("eviction" for cause or residents leaving against staff advice) or "positive" ("graduation" to more independent living) would be expected to have a strong impact on the participants in the residential community.

The questions posed about the discharges under study (see Lofland and Lofland, 1984, Chapter 7) are: what is the process through which they occur and what are their consequences? In investigating these questions the following features of the discharge process were explored:

1. How does the program community identify potential discharges? What are the cultural norms of continuing participation in the program? Who monitors client participation to determine if these norms are being adhered to or violated? How is the discharge process initiated?

2. How do staff see their role and clients' role in the discharge process? How is the discharge decision made and what is the process leading up to it?

3. How do staff interpret the aftermath of discharge for those discharged, for non-discharged clients, for themselves and for the program in general?

In answering these questions the researcher hoped to develop an understanding of the discharge process, the kinds of clients who are vulnerable to negative discharge or destined for positive discharge, and how the process unfolds. Findings could then be used to develop recommendations for program improvement.

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The case of "continued stay" clients is a little more subtle. Here the researcher was concerned with the following questions:

1. Who selects continued stay clients and what is the process through which they are chosen?

2. What are the "terms and conditions" for continued stay?

Sample Selection

The study used a two-tier "purposive " sampling method, with interviews conducted with staff and clients. There were 55 admissions and 33 discharges from Harlem House between its opening in April 1990 and December 31, 1996. Clients who remained in residence for longer than 30 months were considered as "continued stays" (n=11). All available staff were interviewed about all 33 discharges and about all eleven continued stay clients, an example of what Patton (1990) refers to as "comprehensive sampling" method in which every case or instance of a phenomenon is studied, in this case by interviewing all available participants.

A total of 17 staff participated in the interviews. Four staff who were employed in the residence were not interviewed. Three of these left the agency before the interviews began; one left her job suddenly during the interview period. Given staff turnover, the number of staff interviewed about a specific discharged or continued stay client varied somewhat. Overall, during the 6-year study period there was considerable staff continuity until the last half-year period. This continuity was a significant advantage in conducting the research.

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Staff interviews on discharges were conducted both individually and in small groups. The assumption was that discharge is often an emotionally laden topic and that group interviews might provide a comfortable atmosphere in which staff might feel less directly challenged and in which the group might diffuse the high level of emotion. Staff interviews were conducted individually and in groups of three.

The researcher interviewed nine of the eleven continued-stay clients. Of the other two clients, one moved out of state and the other left the agency with no forwarding address.

Three interview guides were developed for the study (see Appendix 1):

1. Interview Guide #1: For staff interviews about discharges

2. Interview Guide #2: For staff interviews about continued stays

3. Interview Guide #3: For client interviews about continued stays.

Constructing the Interview Guides

Interview Guide #1 consisted of eleven questions for staff relating to client discharges. The guide contained questions relating to the staff's experience of the client at the residence, the client's relationships and participation at the residence and in Portal's other programs, how the decision to discharge was made, and staff and client reactions following the discharge.

In designing the guide, the researcher thought that the most natural way for the staff to discuss client discharges would be to open up conversation about a specific client and then lead the respondent(s) through the process. This kind of approach, in contrast to identifying the technical aspects of the discharge process and then trying to have staff

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relate their experience to them, proved to be highly satisfactory. The individual and group interviews flowed smoothly as informal conversations in which each staff member told "the story" of each of the clients that was discussed. In opening up the conversation with the simple phrase, "let's talk about client X's experience in the residence," the researcher established a relaxed atmosphere in which staff responded spontaneously.

Once conversation about a particular client was begun, the researcher maintained the informal tone of the interview. The interviews often followed a similar pattern: the researcher would raise a client's name, the staff member or members would generally respond with their immediate overall reaction to the particular client (i.e., "'X' was quite a handful" or "when I think of 'X' my blood boils" or "'X' was so terrific at the residence."). Then, the researcher would lead the conversation through the staff's experience with the client from admission to discharge, trying to obtain as complete a picture as possible of the client's relationships with staff and other clients, how he or she used the program and services at Portals, how their discharge occurred and the staff and client reaction to the discharge. The concept of "social worth" was never explicitly referred to in the interviews, although the researcher was mindful of the concept in guiding the conversation (see **Research Issues,** below).

By design, the researcher began the questioning by identifying a recent discharge to discuss. This was a good approach since the experience was fresh and staff were comfortable speaking about it spontaneously. Usually, each client was discussed fully before moving to the next client. In some instances, however, staff would make spontaneous comparisons among clients and experiences. The researcher noted these but

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probed minimally, preferring to follow up later in the interviews when the other clients mentioned were being discussed. In this way, the researcher attempted to obtain as a complete data as possible of each of the clients discussed.

The researcher was especially concerned with obtaining as complete a picture as possible of the client's overall participation and relationships in the residence and the process through which he or she was discharged. The guide furnished questions and probes in these two essential areas. The interviews, then, were more than opportunities for staff to tell selected clients' stories. They also focused on the **discharge decision-making process**, the **who, how, why and how** of discharge. This material was included to try to elicit an understanding of staff perspective on their own role in the process, as well as any external factors that may have been salient to the discharge.

The questions regarding the aftermath of client and staff reactions to the discharge were added after a small number of pilot interviews in which some staff had talked about such reactions. These questions provided significant insight into the impact of specific discharges on the program and, retrospectively, clarified how staff viewed their relationships with individual clients while in residence. Such insights contributed significantly to an understanding of how clients were selected for discharge (positive or negative) or continued stay.

Most of the interviews moved from the specific to the general. After having discussed a number of specific discharges, the researcher gave the respondents an opportunity to think more globally by asking questions #10 and #11. These questions asked the respondents to comment generally on the discharge process and (for long-term

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staff) how it might have changed over time and also what improvements, if any, they would make in the process itself. By including these questions at the end of the interview, some respondents were able to apply some of their thoughts and feelings regarding individual discharges to the overall process, which enriched the data considerably.

Interview Guide #2 was designed to obtain data on the staff's perceptions regarding long-term, continued-stay clients. The guide consisted of seven questions in which staff were asked about the individual characteristics, personalities, relationships, participation and any external factors that might bear on clients achieving continued-stay status. They were also asked whether they thought each specific client should continue in residence and why.

These interviews also took the form of informal conversations about the eleven clients in the continued-stay category. The interviews began with the researcher asking the respondent to talk about the experience of having "client X" in the residence and staff telling "the story" of each client from the time of admission. In this way, staff responded spontaneously in the discussion of each of the clients.

As with Guide #1, at the end of each interview respondents were given an opportunity to make general comments about the continued-stay phenomenon. In contrast to this kind of exploration in Guide #1, in which many staff readily generalized about discharges and the discharge process, very few staff made synthetic comments about continued-stays beyond identifying a sub-set of clients whose disabilities clearly consigned them, in staff's minds, to this status. The underlying dynamics of how most

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continued-stay clients were selected by staff remained largely unarticulated and unexplored by staff in the interviews, although they emerged with clarity when the researcher analyzed the data.

Interview Guide #3 was used in the nine interviews conducted with continued-stay clients themselves. The 11 questions focused on the client's experiences at Harlem House, especially their relationships with staff and other clients and their participation in activities at the residence and at Portals. Question 1 asked about the client's lives prior to moving to Harlem House, the length of homelessness, family relationships and previous program experience. The researcher dropped this question after two interviews when he found that the respondents were uncomfortable with it. In subsequent interviews, these areas were explored more indirectly as clients referred to their pre-Harlem House lives in the course of conversation about their experiences at the residence.

Seven of the nine interviews, then, began with the researcher asking the client about their referral to Harlem House and their first impressions of the residence. Clients were asked about their expectations at the time of admission with regard to limitations on the length of stay. They were also asked to describe their first visit to the residence and about their early experiences with other clients and staff. The interview then focused on client's experiences at the residence, their relationships in the residence and at Portals, their opinions about why they remained so long in the program and their plans for the future.

These interviews also took the form of conversations in which the discussion ranged from the clients earliest experiences to their most recent. In the course of each

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client telling his or her "story" the researcher was able to focus the discussion on especially positive and negative relationships and experiences and each client's perspective on why he or she "did so well" at the residence.

While most clients responded spontaneously to most questions, the responses were often one or two words or sentences. These kinds of responses were anticipated in view of the clients' disabilities. Despite the brevity of many of the responses, a readily discernible pattern of responses, discussed in Chapter 8, emerged from the interviews.

Data Analysis

Data analysis proceeded through a number of stages as described by Strauss and Corbin (1990) and Miles and Huberman (1994). Similar methods were used to analyze individual and group-generated data.

Initial micro-analysis (Strauss and Corbin, 1990) of staff-generated data was conducted by coding on a purely "descriptive" basis. Interview notes were coded by the specific client case under discussion, as well as by an assigned staff code identifying the specific respondent. This enabled the researcher at all times to know which specific case was being discussed and which staff member had made a specific comment. Margin notes (made during the interviews or added later when notes were organized to conduct the initial analysis) were made to label the specific area of comment (e.g., client personality, client's relationships with staff, client's relationship with other clients, why client was discharged, deliberative process regarding the specific client, aftermath to the client's discharge, etc.).

Data manipulation and categorization were conducted manually. The first

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analysis focused on reducing the data to their purely descriptive state (see Miles and Huberman. 1994. p. 57 and Strauss and Corbin pp. 11-12.). Data strips were first organized by client case (discharge or continued stay) with all staff comments on a case included. The researcher read through each staff's account of each client case. comparing descriptive differences among various staff members. The researcher was particularly concerned with identifying regularities and irregularities in the staff responses. This initial analysis yielded staff's descriptions of client traits (attitudes and behaviors), a raw description of the categories of negatively discharged clients, descriptions of positively discharged clients, characteristics and categories of continued stay clients and preliminary descriptions of the steps in the discharge process (initiation, deliberation, decision, discharge, aftermath).

This comparative analysis led the researcher to reorganize the data strips by specific descriptive categories within each case (e.g., staff evaluation of the client's problems, personality, relationships, client participation, relationships with staff and clients, events precipitating discharge, discharge process, etc.). The researcher then conducted a second comparative analysis to determine the level of agreement among staff on each of the descriptive categories. The results of this analysis produced a set of comparisons within each case by descriptive category, by each staff respondent, including basic characterizations by individual staff of each client and each staff member's descriptions of the various process elements involved in the client's career at the residence (from admission through discharge or to "continued-stay" status). This analysis yielded insights into the staff's norms of expected client attitudes and behaviors.

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norms of staff participation in the positive and negative discharge process and insights into the aftermath of discharge on clients and staff. This analysis led the researcher to develop a number of tentative themes and interpretations.

With this initial set of regularities and irregularities identified, the researcher conducted a third analysis. Here staff responses in each of the descriptive categories were compared across client cases. This analysis included coding and analysis for "explanation" and theory-building, as well as description. From this analysis, major themes and interpretations emerged which led to the creation of grounded theory.

In this final stage the researcher attempted to develop a holistic understanding of client careers in the program. In several key areas new insights emerged from the data: the "burden of guilt" that staff inevitably experiences in the negative discharge process and its impact on the process (see Chapter 6), the negative bias among staff toward positive discharge(see Chapter 7) and the protection that a valued client role offers those facing negative discharge (see Chapter 8).

During this phase of analysis the researcher consciously used the "flip-flop" technique described by Strauss and Corbin (1990). This involved consciously testing the theoretical regularities that emerged in the overall examination of cases by exploring "exceptional" cases. In Chapter 6, such irregularities are highlighted in the discussion of two cases in which staff norms and standard procedures were violated. In exploring the exceptional nature of these cases, the regularities of the other "ordinary" cases were brought into bold relief and the underlying grounded theory was thereby strengthened.

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Research Issues

The researcher anticipated a number research problems in conducting the study. The first grew directly out of the possible bias inherent in the research method employed. Patton (1990), Strauss and Corbin (1990) and Miles and Huberman (1994) have all stressed the importance of acknowledging research bias in an effort to minimize its effects on data collection and analysis. As discussed above, in the current study the researcher was fundamentally dedicated to the principles of inductive qualitative research and grounded-theory building. These principles include: 1) intense or prolonged contact in the "field;" 2) attempting to gain "holistic" knowledge of a specific set of phenomena; 3) developing understanding of the phenomena under study through the "insider's" perspective; and 4) using the data provided by the insiders (actors, participants) as the foundation for theory-building (see Miles and Huberman, 1990, pp 6-7)

A complicating factor for the researcher in conducting the study based on these principles was the presence of the deductive social science concept, "social worth," in the researcher's frame of reference. A strong predisposition to "find" and measure "social worth" and to chart its effects on client outcomes posed the most serious potential source of bias in the study.

In order to overcome it, the researcher had to be especially vigilant in maintaining neutrality during both data collection and analysis. The "flip-flop" technique (Strauss and Corbin, 1990) described above was one of the ways in which the researcher attempted to cut against the grain of the any possible "social worth" bias (in essence testing for the "null" hypothesis that "social worth" did not exist as a salient factor).

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trying to uncover exceptional cases to shed light on day-to-day processes of residence life and the discharge process. In all instances, the data confirmed the underlying "social worth" processes at work in the program. At the conclusion of the study, the researcher believed strongly that the deductive concept of "social worth" was an important frame of reference which did not jeopardize the researcher's objectivity but which provided both an economical and enriching conceptualization.

A second major area of concern was the researcher's desire to conduct qualitative inquiry despite significant time constraints. Given these constraints it was not realistic to conduct extensive participant observation, which the researcher would have preferred. Open-ended interviewing, the selected major data collection technique, proved to be an economical approach. The use of group interviews, in addition to individual interviews, gave the researcher an important opportunity to observe staff interactions and helped clarify staff and client relationships.

Since the proposed method of study involved open-ended interviews with staff and clients, the researcher was concerned about problems that might arise from staff and client knowledge that the researcher is in the position of Deputy Executive Director of Harlem House's parent agency. In her description of the challenges of fieldwork, Rosalie Wax (1971) presents a number of relevant thoughts in this regard.

Wax stresses the importance of the initial contact phase between researcher and subjects in determining:

> ...the lines of communication and social vantage points through which [the researcher] will make his observations and be permitted to participate. It is also during this stage that he [sic] will find out whether or not he will be able to do the work he wishes to do. And quite frequently it is during

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> this stage that the character, scope and emphasis of his problem or investigation is determined (p.16).

Wax's description of the social aspects of fieldwork guided the researcher in approaching the interview process with the staff and clients of Harlem House:

> Fieldwork is as much a social phenomenon (involving reciprocity, complex role playing, the invention and obeying of rules, mutual assistance and play) as it is an individual phenomenon (involving observation, recording, testing, analyzing, theorizing and model building (p. 363).

Since Wax believes that "most sensible people do not believe what strangers tell them" (p.365), she goes on to suggest that mutual trust between researcher and subjects is not based on what the researcher says, "but by...how he acts, by the way in which he treats them" [the subjects] (p.365).

To acknowledge and address these concerns, the researcher made a number of visits to Harlem House in the fall of 1992 prior to the formal interview process. On weekdays, these visits were scheduled in the late afternoon and evening hours, when residents had returned from Day Program at Portals, Harlem House's parent agency, or other outside activities. Informal visits also occurred on weekends when many residents socialize informally. During these visits, the researcher socialized with clients and staff, joining in meals, card games, parties and the like.

During the spring of 1993, the researcher conducted a number of pilot interviews with staff. At the beginning of each interview, the researcher carefully outlined the scope and purpose of the study and indicated clearly that neither staff performance nor individual resident participation was being evaluated.

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Interview confidentiality was stressed, along with the suggestion that if issues were raised in the interviews that staff thought should be addressed at the program management level, they might wish to pursue these with their supervisor. For purposes of the study, it was made clear that the researcher would not provide direct feedback to the program supervisors, that this would be an option for individual staff members to pursue if they so desired. The researcher reminded several staff about this in the course of their interviews when they had strong suggestions about how a particular case or event could have been handled or about a policy change that they might suggest.

The researcher, attuned to Wax's cautions, was aware that occasionally, an individual staff member would clearly be acting in an over-ingratiating way or would seem to be expecting some form of concrete reward for participating in the interviews. With two staff members, this took the form of hinting at the hope that they might be considered for a promotion. For example, at the end of a second marathon interview with a particular staff member, she looked at the researcher intently and summed up:

> Yes, it's been four really exciting and in some ways very tough years. You know I love my job. I just hope I'll get a chance to move up. [she laughed] So please keep me in mind.

As discussed in Chapter 8, in the course of the resident interviews, the researcher noted that some subjects seemed to portray their experience at Harlem House and Portals in a highly exaggerated, over-idealized way. Granted that the agency and its programs literally rescued many of these individuals from near total destitution and alienation. However, in several instances the researcher felt that subjects were constraining themselves by viewing the agency and its programs only in the most positive light.

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Whether this reflected their awareness of the researcher's position within the agency, was a reflection of the fear that they might jeopardize their services if they complained or was attributable to some other factors, it took considerable probing for some clients to express a more realistic view. Many clients did not want to portray the agency or staff in a negative light:

> <u>Excerpt from Resident Interview:</u>
>
> **Resident:** The staff is so great...They do everything: cook, clean, take care of you when you're sick. If you do something wrong they help you see it and get you back on track. I never knew there were people like this...
>
> **Researcher:** You never had a disagreement with staff or saw them do anything wrong?
>
> **Resident:** [after a moment] No, they're God's blessing.
>
> **Researcher:** Can't you think of a time when you felt staff did something that wasn't fair or right?
>
> **Resident:** [tentatively] Well, when S. [a resident] left I guess we were all really shocked. I couldn't understand it, how L. [the residence director at the time] did that. [This was followed by a discussion of several other examples where the resident questioned staff judgment].

The researcher, then, was alert to the possible impact of his agency position on the subjects and, when sensing that this factor might be coming into play, attempted to probe the area of discussion to overcome any initially biased responses.

The Program Setting

In April of 1990, Portals, Inc. (not its real name), a 45-year-old non-profit mental health and rehabilitation agency in New York City, opened its first community residence

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designed specifically for mentally ill homeless adults. (This was the fifth single-site agency residence developed overall, the four previous programs serving the general population of chronic mentally ill.) Called Harlem House (not its real name), the residence for the homeless was developed with capital funding from the New York State Department of Social Services and the New York State Office of Mental Health. A formerly abandoned, city-owned building located on a busy commercial/residential street in Central Harlem was renovated for the program at a total cost of $1.5 million. The program was licensed as a supervised community residence by the New York State Office of Mental Health, which provides an annual operating contract of about $400,000.

Twenty-four single, formerly homeless men and women live at Harlem House. Admission criteria include an Axis I diagnosis of major mental illness based on the DSMIV, functional disability due to mental illness and referral from a New York City municipally operated homeless shelter. The residence contains six four-bedroom apartments, each of which has a living room, kitchenette, two bathrooms and a separate bedroom for each resident. In addition, the building contains a community kitchen and dining room, a program lounge, laundry facilities and staff offices.

The program has 24-hour, seven-day-a-week staffing. There is a masters level (social worker) Residence Director, Assistant Residence Director (experienced bachelors level paraprofessional), Senior Counselor (high school level paraprofessional) and seven counselors (high school graduates). In addition to daily awake overnight coverage, a Portals staff member, who works in a different agency program, lives at Harlem House

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and is available in the event of overnight emergencies. On all shifts. except overnight. there are at least two staff members "on" simultaneously.

The program at Harlem House includes: a daily morning community meeting; a daily community dinner program in which residents and staff share and rotate responsibilities for shopping, cooking, serving and clean-up (menu planning is done by the whole community in the community meeting); structured and informal socialization programs in the lounge and community room and in the outside community (e.g., trips); and bi-weekly individual meetings between each resident and the Residence Director.

In addition, five of the staff counselors are each assigned a caseload of residents. The counselors visit each of the residents on their caseload weekly in the resident's apartment to formulate and work on the resident's individual Daily Living Skills Plan. These meetings may address the full range of the resident's skills deficits, from budgeting or use of community resources to medication compliance, personal hygiene, apartment upkeep, etc.

During the day, Monday to Friday, residents are expected to attend the day treatment and other rehabilitation programs at Portals or elsewhere. These programs include: case management; structured verbal and socialization groups; vocational and education programs (job training and placement in competitive employment; basic literacy or GED preparation); social, recreational and creative arts activities; primary health care services; mental health services (individual and group therapy, medication); and specialized treatment and related services for clients dually-diagnosed with mental

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illness and substance abuse and those who have HIV/AIDS. Residents may also attend Portals on weekends and holidays.

The goal of the Harlem House residential program is to provide stable, quality housing and to prepare and support residents in their overall rehabilitation. As licensed by the New York State Office of Mental Health, the program is transitional, envisioning resident "graduation" to less supervised and more independent housing within a two to three year period.

Locating the Program in the Study Framework (Chapter 2)

In terms of the typology developed in Chapter 2, Harlem House is an exemplar of a program that views the primary problem of the homeless as psychological estrangement. This was not the agency's original concept in housing the homeless, however. The agency's first efforts failed, when, after simply identifying a group of clients from the shelters and quickly moving them into agency housing (not at Harlem House), it was found that most clients either "disappeared" or simply could not tolerate being "indoors" in their own apartments. The drop-out rate was over 80%.

In reviewing this experience, Portals staff began to formulate the estrangement theory and to build a program concept around it. A second cohort of clients was recruited from the shelters by a newly organized homeless outreach/service program team, consisting of a social worker and two bachelor's level case managers. After working with shelter staff to identify appropriate clients, the team regularly visited the shelter to meet potential clients and lead a group at the shelter. After a period of several weeks, the Portals van began to bring clients from the shelter to the Portals program facility where

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the same staff team offered a low-demand day treatment program. emphasizing basic socialization activities. Clients were given an extended opportunity to form attachments to staff and this program prior to formally exploring Portal housing.

During the period of participation in the low-demand day program. staff took cues from clients regarding their service needs and willingness to accept services. Staff moved at the rate of client interest in such areas as psychotropic medication. substance abuse services. health care needs. obtaining welfare and/or medical benefits. The primary staff role was to offer an opportunity for clients to reformulate positive attachments on which to build later rehabilitation efforts. This occurred both through client participation in the low-demand. nurturing activities of the day program (arts and craft activities. infomal socialization. communal meals and trips. group celebrations of birthdays and special events) and through staff offering concrete help when asked to do so (arranging medical care. advocating for entitlements. etc.). Thus, gaining a sense of <u>community</u> and <u>relationship</u> was the central <u>theory of help</u> of this program.

The agency used this conceptual base to assemble potential residents for Harlem House. The Portals team worked on-site at a number of municipal shelters, introducing itself and leading on-site introductory and preparatory groups. The low-demand program was established at Portals and clients began to attend. Client participation in the low-demand program averaged 4.2 months before the housing transition from shelter to Harlem House.

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The Researcher's Entry into Harlem House

The following field notes convey the researcher's first impressions in visiting Harlem House in the fall of 1992:

Physical Impressions:

Harlem House is located on one of Harlem's busiest commercial and residential streets. When approaching the building (a five-story walk-up tenement), one first observes the grocery store on the street level. English and Spanish sale signs in the windows lure customers. The large independently operated market includes a butcher shop and grocery specializing in a variety of Latino foods.

The entry to the residential portion of the building is at one side of the market. The new entryway clearly indicates the building's recent renovation. The small inside foyer is newly painted, with intercom and mailboxes, but a strong, acrid odor from the grocery store and its basement storage area dominates the senses.

Walking up the newly installed, freshly painted stairway the odor of the market is left behind. On the second floor the residence proper begins. To the left of the central stairs one enter the residence community room, a bright and cheerful space whose two large windows look out on the street below. The community room contains sufficient seating for community meals, with plenty of room to spare. The blond wood furniture looks sturdy and attractive. On a typical afternoon (after residents return from program at Portals), there are likely to be six to eight clients in the community room, playing cards or board games, smoking or simply socializing. One client was observed to be

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nervously pacing the length of the room, holding, but not really focusing on, an open book. His actions did not elicit any particular reaction from other clients or staff, as though this was a familiar behavior.

The community kitchen, where the communal dinner meal is prepared daily, adjoins the community room. A large pass-through window brings the activity in the two spaces together. Inside the kitchen, two clients and a staff member are cooking dinner. The smell of roasting chicken and Spanish-style rice fills the kitchen and community room.

On a wall of the community room, the weekly menu and chore lists are posted. Assignments for shopping, cooking and clean-up and the week's dinner menus are included. Dinner selections include spaghetti with meatballs, chicken, lamb stew, fish sticks, curried goat and a pizza party on Saturday evening.

The laundry facility is also located off the community room. The washer and dryer (provided free of charge) are heavily used from late afternoon until late evening.

Beyond the community room and kitchen is the TV lounge. There is a large-screen television and stereo system. The seating here is on large upholstered easy chairs. There are eight to ten of them as well as a card table and chairs. The TV is on and there are three clients and a staff member comfortably watching it.

Off the TV lounge, in the rear of the building, there are two staff offices. The Residence Director uses the small one and the balance of the staff share the other large one . The large staff office is cluttered. There are three or four desks, a computer, additional seating and file cabinets. On one long wall there is a large photo collage of

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clients and staff at various Harlem House and Portals events, both in and outside the residence. There are also pictures of clients' and staff's relatives, including spouses, children, nieces and nephews and grandchildren. The photo collage communicates a strong family feeling. Often, when staff are interviewed in this room, as they talk about a particular client, they will refer to one of the photos.

The balance of the second floor of the residence consists of a one-bedroom apartment in which a Portals employee (not a Harlem House staff member) lives. This live-in employee (who is the Assistant Residence Director of another residence) often socializes with Harlem House Staff in the staff office and she knows the Harlem House clients well. In the event of a serious emergency between midnight and 8 A.M., when there is only one awake counselor on duty at Harlem House, the live-in employee is available to assist.

The client apartments are on the third, fourth and fifth floors of the building. There are two four-bedroom apartments per floor. At the time of the researcher's initial visits there were two women's and four men's apartments.

In two of the men's apartments the original carpeting in the living room and bathrooms in each apartment appear to be generally well-maintained, although again the female apartment bathrooms are generally cleaner and better-kept.

There are great individual differences in the client bedrooms. Each is furnished with agency-provided bed, night table, bureau, chair, floor lamp and large built-in closet. Some bedrooms are totally undecorated, with bare walls; some (in most cases female) have been elaborately decorated. Some are extremely messy, a few with strong body

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odors and some are very well kept. In several, clients have added additional furnishings and individual "touches" – art, family photos, posters, wall hangings, etc.

Community Meeting 1992:

The following excerpts are from the researcher's field notes describing a community meeting that he attended in the first month of preliminary field visits to Harlem House in October of 1992. Community meetings, for all residents and staff, are held weekly. The purposes of the meetings are to plan the communal dinners for the week and to address resident and staff concerns:

The community room is quiet as people are gathering. Residents take seats around the dining tables and in chairs lining the walls. Some staff are intermingled at some of the tables; some are standing leaning against the wall; two are standing inside the kitchen where there is a pass-through to the community room. The quietness of the group is striking; I'm not sure if it's a tense quiet or not.

D. (the Assistant Residence Director) enters the room and takes the seat left empty next to the pass-through window, at the front of the room. She has a secure air of authority and is clearly in charge of what is about to occur. She clearly runs a tight ship and is very business-like. D. smiles at everyone and nods to one of the clients (who turns out to be the recording secretary), who calls the roll, both clients and staff.

D. introduces the researcher (who already knows about 20 of the 24 clients and all but one staff member), who describes his special sentimental attachment to Harlem House (The first residence which he was involved in developing) and the purpose of the study (i.e., "spending time with clients and staff to get everyone's opinions about how the

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program is going; trying to describe everyday life at the residence and trying to understand its successes and problems.").

The researcher indicates that he will be spending informal time in the residence over the next few months and that he will also be talking with some clients and staff more formally. He indicates that he is at the meeting today to observe and get acquainted. In response to clients' questions, the researcher talks about the confidentiality of the study and the fact that the study will not get into people's personal problems. A client asks if Harlem House is so great, why don't you use our name.

The researcher reviews confidentiality again and says that he wants clients And staff to feel free to offer suggestions and criticisms so it is best to change the identity of the residence. S.(a client whom the researcher knows well) asks if the researcher will come to dinner the following Wednesday when she hopes to be making her "special chicken" for the community meal. The researcher responds that this is the real reason he's conducting the research, "to get a chance to taste everyone's cooking." There is some lighthearted competitive bantering among the clients about various clients' cooking. The researcher playfully participates.

The Assistant Residence Director then officially welcomes back one of the clients returning from a hospitalization. The returning client shyly smiles then, with more confidence and great warmth, thanks those who visited her in the hospital and expresses great relief and gratitude for her return to the residence.

The Assistant Residence Director then begins the formal part of the agenda which

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all participants seem to be familiar with. The division of chores for the coming week is discussed - shopping, cooking, clean-up for the community meal. D. handles the discussion in such a way that those clients who don't readily volunteer for chores are assigned. There are no protests. The secretary writes down all the assignments and reads them aloud. She says they will be posted later that evening. The discussion of menus elicits comments from staff as well as clients. There is negotiating over main courses, side dishes, desserts, etc. A client points out that there are two birthdays next week and asks if there could be Chinese take-out for a celebration one night. The group enthusiastically supports this idea. D. says that she has to consult the budget and she'll report back. In the meantime, plans are made for the full seven nights.

D. moves the agenda crisply to "resident" issues. She asks if any clients have anything to bring up. One client asks about getting some art work of one of their fellow residents who recently died. D. says she will talk to the art therapist at Portals about this possibility. A client asks why the expected painting of the residence has not begun. D. reports that the painter bought the wrong paint and that it was being reordered.

D. asks staff if they have anything. R. a long-time counselor, brings up the issue of smoking in the dining room and TV lounge. R. suggests that some thought be given to limiting the number of people who can smoke at one time, "because the smoke is so bad." As R. speaks, other staff are indicating agreement with him, nodding their heads as he makes his points. It seems that the staff has discussed this issue together before the meeting.

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While clients seem to be unprepared for this subject, two of them respond spontaneously and forcefully. J. says "we have to talk about it if we're going to make smoking rules." N. says "they cut back on smoking at Portals, but this is where we live." Other clients appear concerned. The Assistant Residence Director says that she will appoint a committee to consider the smoking issue and report back to the community. She asks for volunteers and three clients three staff are selected.

The Assistant Residence Director asks if there is any other business. There being none, the meeting concluded with the established ritual of going around the room and each person sharing one piece of "good news." After each person gives their "news" there is a round of applause. Typical client good news includes: "I lost three pounds this week," "I had a good week at Portals," "I'm glad the weekend's almost here," "My support group went for a pizza party," "I had a visit from my daughter this week," "I took a walk with my case manager at Portals." Staff good news includes: "the ashtrays in the community room were emptied," "everyone came down for medication on time this morning," "C. [a client] made a really good lasagna," "At least the painting almost started."

My overall impression is that the meeting is highly structured with strong leadership and a clearly marked agenda. The initial quietness of the clients was replaced with spontaneous participation by many. There was a comfortable dialogue with staff and a feeling of mutual respect and trust.

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CHAPTER 5

Profile of Harlem House Clients and Staff

In conducting the study, the researcher collected salient demographic data on the 55 clients who resided at Harlem House during the six-year study period. The profile of Harlem House clients that emerges from this data clearly indicates that its residents have experienced multiple social problems over relatively long periods. Before discussing the findings, it should be stressed that admission to Harlem House is restricted to those clients who are officially designated as "homeless" by the New York City Human Resources Administration, under the terms of the City-State "New York/New York Agreement," a 1990 housing initiative for mentally ill homeless adults. This designation is reserved for persons who have used the municipal shelter system and are thereby assigned a "shelter number." In the absence of such a designation, potential clients do not qualify for residence at Harlem House.

As Table 5 indicates, over the six-year study period, about two-thirds of the fifty–five subjects admitted were male; one-third female. The mean age at admission was 37.2, with a standard deviation of 11.46. The racial mix of the subjects is presented in Table 6. More than two-thirds of the subjects (70.9%) were African-American. The second largest group was Caucasians, who accounted for 14.6% of the subjects, followed by Latinos (10.9%), Asians (1.8%) and others (1.8%). As shown in Table 7, all of the subjects had a primary diagnosis of major mental illness, according to the diagnostic criteria of the Diagnostic and Statistical Manual of the American Psychiatric

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Table 5. Gender of Harlem House Residents
N=55

	Frequency	Percent
Male	35	63.6
Female	20	36.4
TOTAL	55	100.0

Table 6. Race of Harlem House Clients
N=55

	Frequency	Percent
African-American	39	70.9
White	8	14.6
Latino	6	10.9
Asian	1	1.8
Other	1	1.8
TOTAL	55	100.0

Association (DSM IIIR and DSM IV). 41 of the subjects (74.5%) were diagnosed with schizophrenia. 12 subjects (21.9%) were diagnosed with major affective disorder (bi-polar or major depression with psychotic features), one was diagnosed with an undifferentiated psychotic disorder and one had a primary diagnosis of poly-substance

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abuse. (These percentages approximate the overall diagnostic distribution of Portal's total client population of 625 adults).

Table 7. Diagnosis of Harlem House Clients
N=55

	Frequency	Percent
Schizophrenia/ Schizo-Affective Disorder	41	74.5
Bi-Polar/Major Depression	12	21.9
Other Psychotic Disorder	1	1.8
Polysubstance Abuse	1	1.8
TOTAL	55	100.0

Data on length of residence in New York City was collected in order to determine the percentages "new arrivals" versus long-term City residents. Table 8 shows that 47 of the subjects (85.4%) resided in the City for more than eight years and that only two residents lived in the City for three years or less. The vast majority of the residents of Harlem House admitted during the period were long-time City residents.

The subjects were asked about the length of time they were homeless prior to moving to Harlem House. If a client was referred to the residence from a hospital, the hospitalization period was included in the length of prior homelessness. Table 9

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Table 8. Length of Residence in New York City
N=55

	Frequency	Percent
Less Than 1 Year	1	1.8
1 To 3 Years	1	1.8
4 To 8 Years	6	11.0
More Than 8 Years	47	85.4
TOTAL	55	100.0

illustrates that most Harlem House residents were homeless for extended periods prior to admission to Harlem House. 42 clients (76.4%) were homeless for more than one year prior to admission, 11 clients (20%) were homeless for a seven to twelve month period. 2 clients (3.6%) were homeless for three to six months, while no clients were homeless for less than three months.

The subjects were asked where they resided immediately prior to admission to Harlem House. Table 10 shows that 33 clients (60%) came directly from shelters or drop-in centers, 17 clients (31%) came from hospitals, 3 (3.6%) were referred from prison or jail and 2 (3.6%) were staying temporarily in an apartment or single-room occupancy hotel.

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Table 9. Length of Homelessness Prior to Admission to Harlem House
N= 55

	Frequency	Percent
Less Than 3 Months	0	0
3 To 6 Months	2	3.6
7 To 12 Months	11	20.0
More Than 1 Year	42	76.4
TOTAL	55	100.0

Table 10. Place of Residence Immediately Before Harlem House
N=55

	Frequency	Percent
Shelter	33	60.0
Hospital	17	31.0
Prison	2	5.4
SRO	1	1.8
Apartment	1	1.8
TOTAL	55	100.0

Table 11 presents findings on psychiatric hospitalization history. 51 clients (92.7%) reported a psychiatric hospitalization history. Of those who reported hospitalizations. 14 (27.5%) reported having had more than 6 hospitalizations during their

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lives. 27 (52.9%) reported having had 1 to 3 hospitalizations and 10 (19.6%) reported 4 to 6 hospitalizations.

Unexpectedly, four clients reported no hospitalizations (7.3%). This probably reflects the limitations of self-report data discussed in Chapter 1. A content analysis of the 55 client records indicated that virtually all subjects had a history of at least one documented psychiatric hospitalization.

Table 11. Reported Number of Psychiatric Hospitalizations Prior to Admission to Harlem House N=55

	Frequency	Percent
None	4	7.3
1 To 3	27	49.0
4 To 6	10	18.2
More Than 6	14	25.5
TOTAL	55	100.0

The findings were similar in the area of alcohol/substance abuse history. While Table 12 indicates that 17 clients (30.9%) admitted to a previous alcohol or substance abuse problem, a chart analysis revealed that 65% of the clients experienced an alcohol or substance abuse problem during their stay at the residence, indicating that the limitations of the self-report data.

Table 13 presents medical history data. 14 clients (25.5%) reported having had serious medical problems prior to their admission to Harlem House. "Serious" conditions

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Table 12. Reported Substance/Alcohol Abuse History
N=55

	Frequency	Percent
Report No Substance/ Alcohol History	**38**	**69.1**
Report Prior Alcohol Abuse Only	**8**	**14.5**
Report Prior Substance Abuse Only	**6**	**10.9**
Report Prior Alcohol & Substance Abuse	**3**	**5.5**
TOTAL	**55**	**100.0**

were defined as any life-threatening condition or serious chronic condition (e.g., TB. HIV. hypertension. diabetes. cancer). With 6 non-responses in this category and 35 "no" responses. these self-reported medical problems probably seriously underestimate the medical care needs of the clients. Again. in reviewing Harlem House charts. more than three-quarters of the clients were found to have significant medical problems that required primary and/or tertiary care intervention during their stay at the residence. Educational and vocational histories are reported in Tables 14. 15 and 16. In Table 14. 31 clients (56.4%) reported that they had not completed high school. while 24clients (43.6%) reported that they were high school graduates. Of the 24 high school graduates. 1 (1.8%) completed technical school. 2 (3.6%) attended college but did not graduate and 1 (1.8%) completed a four-year college degree.

Table 15 reveals that 47 clients (85.5%) reported that they had not "worked for

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Table 13. Reported Prior Medical History
N=55

	Frequency	Percent
Yes	14	25.5
No	35	63.6
No Response	6	10.9
TOTAL	55	100.0

graduate and 1 (1.8%) completed a four-year college degree.

Table 15 reveals that 47 clients (85.5%) reported that they had not "worked for pay" during the two-year period immediately prior to their admission to Harlem House. 4 Clients (7.2%) reported that they had worked during the period; 4 clients did not respond to the question. Table 16 reports the employment data on the six clients who claimed to have been employed during the 24-month period. 4 of the 6 clients who worked (67%) said they worked "occasionally at odd jobs," while 2 clients (33%) reported "regular employment," in one case for 1-3 months and in the second case for 3-6 months.

Finally, clients were asked about their contacts with family and friends prior to their admission to Harlem House. Table 17 indicates that 31 clients (56.4%) reported that they had some contact with family members prior to their admission to the residence. 2 clients (38.2%) reported no family contact, while 3 clients did not respond to the question. Table 18 reveals that of those who reported family contact, 67.7% (21 clients)

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Table 14. Educational Attainment
N=55

	Frequency	Percent
Less Than High School	31	56.4
Completed High School	20	36.4
Completed Vocational Or Trade School	1	1.8
Some College (Did not Complete)	2	3.6
Completed College	1	1.8
TOTAL	55	100.0

Table 15. Employment History In 24-Month Period
Prior to Admission to Harlem House
N=55

	Frequency	Percent
Reported Employment During 24-Month Period	6	10.9
Reported No Employment During 24-Month Period	47	85.5
No Response	2	3.6
TOTAL	55	100.0

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Table 16. Reported Length of Employment In 24-Month Period For Those Who Reported Employment Prior to Admission to Harlem House
N=6

	Frequency	Percent
Occasionally at "Odd Jobs"	4	67.0
Regularly 1 To 3 Months	1	16.5
Regularly 3 To 6 Months	1	16.5
TOTAL	6	100.0

reported that their contact with family was less than once every three months. 7 clients (22.5%) reported family contact on a monthly basis and 3 clients (9.7%) reported weekly contact.

Table 17. Family Contacts Prior to Admission to Harlem House
N=55

	Frequency	Percent
Reported Family Contacts	31	56.4
Reported No Family Contacts	21	38.2
No Response	3	5.4
TOTAL	55	100.0

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Table 18. Frequency of Family Contact Prior to Admission To Harlem House N=31

	Frequency	Percent
"Occasionally" (less than every 3 months)	21	67.7
"Frequently" (about once a month)	7	22.6
"Very Frequently" (about weekly)	3	9.7
TOTAL	55	100.0

A larger number of clients reported other social contacts prior to their admission to Harlem House. When asked about their contacts with "friends" prior to admission (Table 19), 41 clients (74.5%) claimed to have had such contacts, while 10 clients (18.2%) reported no contact and 4 clients (7.3%) did not respond. As reported in Table 20, for those who had contact with friends, more than half (54%) claimed that contacts with friends were "very frequent" (at least weekly), while 41% characterized their contacts with friends as either monthly or "occasional" (less than every three months). Thus, a significantly greater percentage of Harlem House clients saw themselves as having more social contact with friends than with family in the period prior to admission to the residence.

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Table 19. Contact with "Friends" Prior To

Admission to Harlem House
N= 55

	Frequency	Percent
Reported Contact with "Friends"	41	74.5%
Reported No Contact with "Friends"	10	18.2
No Response	4	7.3
TOTAL	55	100.0

Table 20. Frequency of Contact With Friends Prior to Admission to Harlem House
N= 41

	Frequency	Percent
"Occasionally" (less than every 3 months)	7	17.1
"Frequently" (about once a month)	12	29.2
"Very Frequently" (about weekly)	22	53.6
TOTAL	41	100.0

Client Profile Summary

The 55 residents of Harlem House during its first six years of operation were predominantly male. More than two-thirds of the residents were between the ages of 26 and 48, with a mean age of 37.2. Racially, almost three-quarters of the clients were African-Americans.

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In terms of mental illness diagnosis, three-quarters were diagnosed with schizophrenia, with all but one of the remaining one-third diagnosed with major affective disorder (bi-polar disorder, major depression with psychotic features).

The research found that the overwhelming majority of residents had been in New York City for much of their lives, disproving the assertion that many mentally ill homeless are "new arrivals." The length of homelessness prior to admission to Harlem House was found to exceed one year for three-quarters of the clients, reflecting a period of protracted deprivation and personal crisis. More than 90% of the residents were referred directly from shelters, drop-in centers or inpatient psychiatric units in State, municipal or voluntary hospitals.

Although self-report data indicated significant psychiatric and substance abuse histories, previous psychiatric hospitalization and substance abuse treatment experiences were significantly under-reported when compared to documentation in client records. In reviewing records, virtually all clients were found to have had psychiatric hospitalizations prior to admission to Harlem House, while 65% of clients experienced a substance or alcohol problem while in residence, suggesting that substance use prior to admission was under-reported. Similarly, the number of clients with serious medical histories was found to be higher in the chart reviews than in the self-report data.

The overwhelming majority of clients had poor educational backgrounds and work histories. More than half did not complete high school and only one completed college. More than eight in ten clients reported that they had no work experience in the two years prior to their admission to the program.

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Finally, in terms of family and social contact, about half of the clients reported having such contacts prior to admission, although, for most who had such contact it was infrequent. Social contact with friends was reported by three-quarters of the clients, with such contact being described as "very frequent" by more than half of those who had such contact. Clearly, the residents viewed themselves as having meaningful relationships during their protracted periods of homelessness.

Staff Profile

Over the six-year study period, a total of seventeen staff worked in the residence. In chapters six, seven and eight, staff are identified by the corresponding letters that appear next to each description below:

Residence Directors (A-B):

Residence Director A: 53 year-old white male masters level social worker with more than 25 years of experience in working with seriously mentally ill adults, including running residential and outpatient programs. Hired as a new employee to manage Harlem House. Harlem House Director from 1990-1995.

Residence Director B: 50-year old white male masters level social work with 10 years of experience at The Bridge. Previously worked in day treatment and other residential programs. Harlem House Director in 1995-1996.

Assistant Residence Directors (C-D)

Assistant Residence Director C: 37 year-old bachelor's level Latino-American female with 6 years of experience at The Bridge. Started at The Bridge as Housing Counselor in single-site residence; promoted to Senior Counselor. Harlem House's first Assistant Residence Director.

Assistant Residence Director and Senior Counselor: 34 year-old bachelor's level African American female with 5 year's of experience at The Bridge. Originally hired as Housing Counselor, promoted to Senior Counselor at Harlem House and then Assistant Residence Director.

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Senior Counselors (E-F)

Senior Counselor E: 28 year-old bachelor's level Latino American female. Worked at The Bridge for two years prior to assuming position at Harlem House.

Senior Counselor F: 36 year-old bachelor's level African American female. Worked at The Bridge for 3 years prior to assuming position at Harlem House.

Counselors (G-Q)

Counselor G.: 23 year-old African American male high school graduate. First human services job; original counselor at Harlem House;

Counselor H: 24 year-old Latino American male high school graduate. First human services job; original counselor at Harlem House.

Counselor I: 41 year-old African American male high school graduate. Previous human service experience; original counselor at Harlem House.

Counselor J: 39 year-old Latino American male high school graduate. Previous experience as Bridge Housing Counselor; original Harlem House Counselor.

Counselor K: 30 year-old Latino American female high school graduate. Previous experience as Bridge Housing Counselor; original Harlem House Counselor.

Counselor L: 28 year-old Caribbean American female high school graduate. Previous experience as Bridge Housing Counselor.

Counselor M: 24 year-old Latino American female high school graduate. First human services job.

Counselor N: 27 year-old Latino American female high school graduate. First human services job.

Counselor O: 25 year-old African American female high school graduate. First human services job.

Counselor P: 28 year-old African American male high school graduate. First human services job; original Harlem House staff.

Counselor Q: 30 year-old African American female high school graduate. First human services job; original Harlem House staff.

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CHAPTER 6

Negative Discharges and the Discharge Process

The researcher conducted open-ended interviews with staff about the twenty clients who were "negatively" discharged over the six-year study period. The researcher's assumption was that these clients, discharged "for cause" or leaving the program "against staff advice," comprise a low social worth group. The categories and sub-categories of negatively discharged and the negative discharge process explored in this chapter, reflect a process through which clients are assigned low social worth and become vulnerable to negative discharge.

In general, negatively discharged clients share a number of important behavioral characteristics: they either frustrate staff professionally, overburden them or flagrantly break specific community norms or rules such as the prohibitions against verbal or physical assault or the use of illegal drugs or alcohol on-site. However, what clearly makes them prone to discharge is their "negative" attitude and lack of redeeming or positive qualities with which staff can identify. As predicted by Hasenfeld's theory, clients to whom staff attribute such "positive" qualities (discussed at length in Chapter 8) are "given more chances" than those who staff view as lacking such positive qualities.

Community life at Harlem House revolves around a series of prescribed and more spontaneous activities. The prescribed activities (the daily community dinner, weekly community meetings, individual counselor visits for ADL training and medication routines) bring clients and staff into formal interactions. These activities require both

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client cooperation and a minimal level of ego functioning (i.e., ability to remember appointments and tasks, concentration, ability to form relationships with staff and other clients).

As we shall see in reviewing the sub-categories of clients who are vulnerable to discharge, low social worth attributions by staff revolve more around client attitudes than their abilities to carry out tasks. Staff are clearly seeking gratifying relationships with clients. At a minimum, such gratification is expressed as an acknowledgment that a particular client is cooperative and making some efforts to participate in a normatively acceptable manner **(Note that staff identifying information appears on pp. 119 and 120 in Chapter V.).**

> <u>Senior Counselor D:</u>
>
> It's not all that complicated here in terms of what staff expect. First of all we're looking for the right attitude. Most of the time, this is the most important thing. We have a lot of clients who can't do things very well and who need a lot of help. Staff will give it if the client responds and at least tries.

While staff acknowledge that there are limits to how far they are willing to go to assist clients who have poor skills (as we shall see, one of the sub-categories of negatively discharged clients are "parasites" who require an inordinate amount of staff time). As a rule staff are willing to work with less able clients, even over long periods of time. The research revealed that client <u>attitude</u> and <u>effort</u> are clearly the key intervening variables in determining staff's willingness to work with them.

Low social worth clients form "defective" relationships with staff that in some specific way preclude the possibility of staff having a professionally or personally

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satisfying experience. In the most generic sense, then, it is staff's perception of an absence of mutual relationship that leads to the designation of low social worth clients and to their subsequent vulnerability to discharge.

The Missing Factor: Psychopathology

It is striking to note, therefore, that in all of the interviews about negative discharges conducted for the study, staff very rarely addressed the question of clients' psychiatric functioning in relation to their undesirable behaviors or negative discharge. That is, the clients' severe pathology (major mental illness diagnosis) is all but suspended by staff and, as reflected in the negative discharge categories and sub-categories, staff's evaluation of clients revolves largely around day-to-day experiences in managing individual clients and the residence. One speculates that if staff acknowledged the clients' poor psychiatric functioning, they would be faced with a "crisis of responsibility." How could staff reasonably hold clients to a standard of behavior if the clients' judgment was seen as being severely impaired by their mental disability? And, if clients could not held accountable for their behaviors, then the "burden of guilt" that staff would feel surrounding negative discharge would certainly increase.

The Residence Director suggested an explanation of why staff suspend the clients' pathology in their judgments:

> Residence Director A:
>
> A major goal of the residential setting is taking care of basic living needs and if you spend too much time focusing on the thought and emotional disorder as being beyond their control due to their being mentally ill, then you're liable to paralyze yourself in not being able to maintain routines and rules. So you look more at people's strengths, which is good, and their ability to choose their behaviors,

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which isn't always fair to the clients.

This phenomenon will be discussed below in the exploration of staff reactions to negative discharges. For now, it is important to underscore that the clients' psychiatric disabilities are largely absent in the staff's discussion of them. These themes of client social worth ratings being based on their observable behaviors and attitudes and staff's consistent view that clients are to be held accountable for their behaviors and attitudes despite their mental illness, run throughout the staff's discussion of negative discharges. The sub-categories of low social worth, negatively discharged clients that were revealed by the research clearly reflect them:

"Non-engagables"

The first sub-category of low social worth negative dischargees are the "non-engagables," those who do not form minimal relationships with staff despite staff efforts. Staff express great frustration with such clients, five of whom were discharged relatively quickly from Harlem House during the period. These are clients who clearly do not meet the staff's requirement for the establishment of a baseline relationship which staff require as a pre-requisite for a potentially gratifying relationship. Clients who cannot form baseline relationships with staff are vulnerable to negative discharge as described by staff:

> Counselor P:
>
> H. lived in the residence for a few months. Most of the time, we hardly ever saw him. He would leave the residence early in the morning, most times returning late at night. But even when he was here, it's like he wasn't. He just wouldn't relate to anyone, not staff or clients. One day he just disappeared. When we located him a week later in the "psych" unit at Coney Island Hospital, we all agreed he shouldn't come back to

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the residence.

> We felt totally helpless with him. He was unreachable. I tried, we all tried every approach. The thing is, we've had quiet and withdrawn clients before. But they eventually begin to connect and it's a great feeling. With H., though, it was different. With all of our training and experience, we couldn't help him. It was like a lost cause; you didn't want to give up, but you had no choice.
>
> Counselor K:
>
> H. actually scared me. I never encountered anyone who was so closed off. He was so void of emotion and uncommunicative you just couldn't reach him. He wouldn't let anybody in.

The fact that staff moved so quickly to discharge such a client, at the earliest opportunity, clearly reflects their insistence that a baseline relationship must be established with clients in order to establish their willingness to work with a client over time. Even if "non-engagable" clients place little or no demands on staff and don't "act out" in any way, they are still assigned low social worth and are vulnerable to discharge. This idea was typically expressed by staff this way:

> Counselor J:
>
> I know we could have let R. stay quietly in the residence. He didn't bother anybody and wasn't demanding. But, we're not just landlords. They've got to be willing to work with us. I'd rather have ten M's (a client who needs considerable staff assistance, but who staff describes as "related") than one R. If you're just getting a blank stare back, what's the point?

Staff, then, are looking for baseline and gratifying relationships with clients beyond their role of being custodial caretakers. Given their needs for gratification in the client-staff relationship, staff view "non-engagable" clients as professional frustrations. They often described extra efforts to engage them:

> Counselor Q:

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We talked about it at the staff meeting. I was determined to get something going with H. I tried to get him to play spades. We tried to teach him, but he would sit there, like a two-year old and not respond. Really his only social interaction was shaking his head "yes" or "no" or asking for cigarettes. On rare occasions he would give a one-word response.

Then, something amazing happened. H. showed some poetry he had written to one of the other counselors. It was beautiful, very sensitive. But in a way the poetry made it worse. He had a soul; we just couldn't reach it. The contact with his counselor never developed further. It was sad. Staff did have a feeling for him. When he disappeared, we sent staff all over looking for him. We had a breakthrough with another introverted client and we hoped it would happen with H. But in the end, even though we cared, we lost our hope.

Counselor P:

H. was like beating your head against the wall. You couldn't get anywhere. I was trying to be a good worker but just got that stare back from him. We're here to do a job, that's what they pay us for. And you know, if the clients can't meet us half-way what's the point?

Several staff were critical of the decision to admit a client like H. to the residence in the first place. D., the Assistant Residence Director expressed this frustration:

Assistant Residence Director C:

I know I was part of the decision to bring H. in, but looking back I know it was a bad decision. He came to dinner at the residence three times before we made the decision to admit and really all he did during those dinners was eat and smoke. He didn't talk to anyone, staff or clients. We should have seen the writing on the wall.

As a group, "non-engagables" have the shortest length of stay of any category of discharged clients. This is viewed as a positive by staff.

Counselor J:

After a couple of months, I knew K. just couldn't make it here. She never spoke and staff was going crazy. But we couldn't just throw her out. So we all tried to ignore her. I mean we were really *cold*, and we all waited for something to happen so that she would be out. When it happened after

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a couple of more months. I thought at least it didn't drag on for years.

In discussing H., K. and other "non-engagables," then, staff described their initial sense of challenge and ultimate feelings of frustration in not being able to establish a baseline relationship with such clients, the necessary condition for a gratifying relationship.

> Counselor Q:
>
> G. was my client and in the beginning I really tried. I thought we could get him out of his hell, but he was nowhere. I used to sit and think "Come on man give me a break; give me something, some little thing to start." I couldn't find it, though. He just didn't give anything.

We see then, that the low social worth assigned by staff to "non-engagables" reflects staff frustration in not being able to establish the necessary conditions for a satisfying or gratifying relationship.

"Parasites"

The second sub-category of negatively discharged clients are the "parasites," those who overburden staff with persistent or unusual demands while offering no positive feedback to staff (i.e., gratitude) or, in staff's judgement, making even minimal efforts to address their own self-care needs. These are intensive users of staff services who require assistance with even basic daily living activities (e.g., bathing, toileting, dressing, apartment upkeep). These clients often have poor personal hygiene habits and very messy rooms that broadcast body odors. They not only dominate the staff's time, but many of the tasks that staff must perform for them are often distasteful.

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What sets these clients apart from others who demand significant staff time is the staff's perception that "parasites" display poor attitudes: they are usually portrayed as both ungrateful of staff efforts (staff often refer to them as being "entitled") and/or as uninterested or unmotivated in achieving even baseline functional levels in self-care. Here we see a similarity to staff attitudes towards "non-engagables." Staff express a strong criticism of what they perceive to be "one-way" relationships in which clients use (or abuse) services without establishing any kind of mutual relationship.

F. was such a client. Forty-one years old, he had a long history of homelessness, having lived on the street for more than four years, revolving in and out of acute psychiatric hospitalizations. At the time of F.'s referral to Harlem House he was psychiatrically stable, completing an inpatient stay at a municipal hospital. Once at the residence, however, it became clear that he would be very demanding of staff time, even for the most simple tasks and his attitude did not meet baseline staff expectations.

> Counselor I:
>
> I couldn't believe how much help F. needed with everything (his emphasis). I thought, O.K. I'll work with him and he'll progress and adjust to Harlem House and be able to take better care of himself. Well, it didn't work out that way. I was spending so much time with him that I was neglecting my other clients. I wouldn't have minded but his attitude (his emphasis) was awful. He never thanked me never even he indicated he cared. And there was no effort at all to try.
>
> He just got worse, couldn't control his bladder or bowels. I literally pleaded with him to use pampers but he wouldn't . We had him checked out physically and he was O.K. Dr. M. [The Portals psychiatrist] tried everything [psychotropic medication], but F. didn't respond. His roommates were mad and I was at the end of my rope. I would try to talk with him about it but he didn't respond.

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Counselor G:

When you have a client like F., it just doesn't work. It's bad enough we had to change and feed and dress him. I felt so sorry for D. [F's counselor]. He had to do everything for him while F. never even tried.

J. was another client labeled by staff as a "parasite."

Counselor P:

J's ADL's were unbelievably poor. The smell was too much. We knew that it was her illness and we hoped that she would improve if we worked at it. But as the weeks went on there was no improvement. Staff had to do everything and she actually got worse, made more demands with an entitled attitude that would kill you. It's like she acted like she had a right to expect everyone to do everything for her. The staff was turned off. M., J.s counselor, told me he couldn't deal with it any longer. He said he didn't take the job to be someone's personal maid or nurse, even though he understood it was the illness it didn't make any difference to him. He wanted someone else to take over.

We talked it over with L. [the Residence Director] who agreed to the change. At a staff meeting L. said that clearly J. did not belong in a community setting in her current condition that she really should be in a state hospital, but that they wouldn't take her. L. said that as long as J. was in the residence someone would have to work with her and that we would have to share the burden. He said that M. had been doing it for two months and now it was someone else's turn. Believe me staff was not happy.

...A short time later, J. was hospitalized. At the staff meeting we talked about whether to take her back. It was a no-brainer; no one wanted to.

In talking about "parasites," staff make the clear distinction between clients who lack basic physical care skills and demand assistance in an entitled or non-cooperative fashion versus those who require considerable intervention but have a grateful or more positive attitude. If staff believe their efforts with the latter group might be successful, they are willing to extend themselves.

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Assistant Residence Director C:

> There's a big difference between clients like F. and J. who are over the line in the physical care they need and don't or can't even try compared to clients like M. or S. who need constant assistance in taking care of their apartment or taking meds, but they work with you and you feel they're making the effort. If the cooperation is there and they respond, staff is willing.

Initially, then, staff will sympathize with clients who have serious ADL deficits and view them as a challenge. But, if clients remain unresponsive or exhibit an entitled attitude, staff become frustrated and resentful. When such clients are hospitalized, leave the residence without permission or become unmanageable in some other way (i.e., verbally or physically abusive), they are often singled out for discharge.

"Unpredictables"

"Unpredictables," a third category of clients who form "unsatisfactory" relationships with staff, are apt to frighten staff and unsettle the residential community. This sub-category consists of clients whose sometimes violent behavior lacks any discernible pattern or immediate/discernible cause. The unpredictability of the client's behavior is a major concern for staff, who often feel betrayed or hurt when clients act in this manner. If the behavior recurs, if the staff is unable to understand it and if the client exhibits either no interest or ability to engage in a process to understand it, he or she is assigned low social worth, with a high risk of negative discharge.

E. was a client whose periodic outbursts at first baffled and then frightened staff. Staff's reaction followed the pattern just described.

Counselor H:

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E. was here for six or seven months. He was smart. He had an associate's degree in accounting and drove a taxi. His high intellectual functioning made it hard for us in a way. We couldn't understand his behavior.

His first violent outbursts were shocking. I'll never forget how he just turned around and started screaming. I was in the kitchen and had no idea what happened. We questioned everybody who was there and him and no one could give a reason, not him or R. [his counselor] or L. [the residence director].

Staff put up with this for awhile, but R. [his counselor] was especially upset because he was trying to understand him and not getting anywhere. R. and L. [the residence director] had a couple of meetings with E. to try to understand. I remember L.'s frustration when he told us about it at the staff meeting. L. was tapping his foot on the floor which we knew meant he was frustrated and he got that southern drawl which always happens when he's angry. He couldn't figure E. out, nobody could.

One day E. said to me, "I'm feeling homicidal," and this just stopped me in my tracks. I was here in the office with no way out. It wasn't like he was expressing a feeling to explain it to you; he looked wild and out of control. None of us felt comfortable talking to him in here. I started shaking and luckily G. [the sleep-in counselor] came into the office and saw what was happening. I called 911 from the other room while E. was pacing. Before the police came, E. broke the wall with his fist and G. [the Counselor] tried to restrain him.

This was as far as the staff would go with E. We had tried to get a handle on it, had so many meetings with Dr. O. [E.'s treating psychiatrist at Portals] and she had tried a lot of different medications. So, while E. was in the hospital after this incident we [the staff] talked about it; no one wanted to take him back.

J., another "unpredictable," who was discharged within three months of moving into the residence:

Counselor I:

The staff was worried about J. No one could figure out why he would go off like that without anything happening you could really point to. One day J. and S. [another client] and I were cooking dinner. We were talking and joking while we cooked. Suddenly J. was in S.'s face, yelling like

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crazy. I felt my blood pressure go through the roof; I didn't know what was going to happen. There was a pot of boiling water on the stove and I just kept thinking, he's going to throw it at someone. A.[the Assistant Residence Director] came in and we tried to calm J. down I swear we couldn't figure out what made him go off like that. At the staff meeting, people got really upset. L. [the Residence Director] had to calm us down: the staff couldn't understand it and were fed up.

The staff attitude toward "unpredictables" was summed up this way:

> Counselor J:
>
> We know that the clients have problems, some very serious problems; that's why they're here. And, OK, the first time somebody blows you do your best to understand it and work with it. But when it keeps happening and you don't know why you get scared. You feel unsafe and upset because you can't predict it and you feel the other clients aren't safe. There's no choice, they've got to go.

"Blatant Rule-Breakers"

The Harlem House community operates on the basis of a number of well-established norms (mutual respect, individual responsibility and communal participation) as well as some specific rules, some of which are imposed by Portals and some of which are specific to the program. Complying with house rules can be a serious problem for some clients.

There are rules at Harlem House in several major areas: paying the monthly client fee (the government funding formula for Harlem House includes the clients paying a portion of their Supplemental Security Income to Portals); no illegal drug or alcohol use on the premises; no unauthorized visitors in the building; no unauthorized overnight guests: no verbal abuse or physical violence; required participation in community meetings and individual ADL visits; following curfew procedures (the street door to

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Harlem House is locked and clients do not have the key; clients who are planning to stay out after 11:00 P.M. or overnight must let staff know); no stealing or other illegal activities.

A. , the Assistant Residence Director, expressed her thoughts about the difficulty that some residents have with Harlem House rules this way:

> <u>Assistant Residence Director C:</u>
>
> Many of our clients have a very hard time with rules. Don't forget they were homeless and many of them can't tolerate structure in their lives. So even though they come from a shelter, living really miserably, they don't necessary see Harlem House as the answer to their prayers. The building is beautiful and all that, and they want the housing, but some clients see rules and structure as taking something away from them, taking away their freedom.
>
> Most clients adjust but some don't. They become angrier and angrier and won't cooperate or they make a point of breaking the rules. Staff can get angry and frustrated; they see the writing on the wall. L. [the Residence Director] talks about "the call of the wild" for some clients. They really want out and they know exactly how to get out. We can explain everything, go over it a thousand times and they're not buying it.

However, although staff understand the difficulty that some clients have with rules, "blatant rule-breakers" still pose a direct "relationship problem" to staff. Since rules are clearly explained and full compliance is expected, breaking of rules is viewed as a breach of relationship between staff and clients and is very difficult for most staff to tolerate. Staff interpret client non-compliance as a direct challenge to their authority and as a betrayal in their relationships with such clients. Thus, beyond a usually short "honeymoon" period or beyond the first instance of rule-breaking, those clients who

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continually and in staff's view consciously refuse to comply with the residence's basic rules are assigned low social worth and are vulnerable to discharge.

> Counselor K:
>
> Most of the time you can understand and accept it, when a client you have worked with and have a relationship with loses it, a slip or momentary loss of control. But some clients are either just trouble from day one or they become trouble. They look for a way to push the staff's buttons and they lean on the button as often and as hard as they can. These are the clients who are argumentative, combative, stubborn and won't take any guidance. They want to fight and breaking the rules is almost like a game for them.
>
> It's really tough for the staff. The first time it happens you forgive and try to get the client to see the problem. But when it continues you get angry back. Especially when you make it clear that they are risking discharge and they continue to disobey. Finally, even though you know what life will be for them back outside, you give up. You admit to yourself there's nothing you can do to save them.

"Blatant rule-breakers," then, clearly challenge the staff's professional skills, their authority and their expectation that clients will participate with them in a mutual relationship. Staff express frustration, acknowledging their failures with such clients which often lead to relatively quick discharge. D. was a typical case of this type, having been referred to Harlem House from a hospital-based homeless transitional living program.

> Counselor J:
>
> D. would throw it right in your face. She just wouldn't stop; you could talk to her for hours and it's like she didn't hear at all. The next day she would throw it right in your face all over again to the point where you forgot you were dealing with a client.
>
> I saw so may staff lose it with her. You never want to lose control or "let them see you sweat," but D. was always causing trouble and then arguing with you if you pointed it out to her. We tried everything – heart-to-

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> hearts, contracts – nothing worked. She was always threatening to leave and I thought: "this can't go on; we're [the staff] being suckered; fine, I'll help you pack."

"Blatant rule-breakers" fall into a number of sub-categories: "deadbeats" (those who refuse to pay their monthly fees), the physically violent, the verbally abusive and "High Boys" and "High Girls," those who use illegal drugs or alcohol at the residence.

"Deadbeats":

The rules and procedures regarding the payment of client fees are imposed and closely monitored by Portals central management and senior residential management. All clients are expected to agree to a "two-party" check system in which Portals is named as "representative payee" for SSI payments. Since this income stream is vital to the overall funding of the residential program (accounting for about 30% of its total budget), staff understand that client cooperation with fee arrangements is essential. Staff know that senior residential and central Portals management will react very strongly when clients refuse to pay or pay late.

> Counselor M:
>
> When G. arrived from the shelter he didn't have benefits. He agreed to go with J. to apply for them, but then balked. We had a huge hassle over it and L. [the Portals Director of Housing] and P. [the Portals Finance Director] got involved.
>
> We were frustrated because we thought we could work with G. and the staff at [the shelter] worked with him for months to get him to agree to come to the residence. I had one meeting with him to try to explain the fee and he went into a rage and I almost did too, it was just that frustrating. After weeks of this, I couldn't excuse it anymore. He understood but he just didn't want to cooperate. We moved him to a local hotel and paid for two months, but he was back on the streets in a couple of days.

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One might expect that staff would assign greater importance to other values, such as the basic desire to "rescue" clients from homelessness, than compliance with agency fee policies. The research revealed, however, that staff at all levels appear to have strongly incorporated the agency norms regarding client fees, clearly reflecting its financial concerns. In protecting the agency's financial interests, staff often expressed ideas about the fee in "pseudo-clinical" terms:

> <u>Counselor P:</u>
>
> When a client pays the fee they are fulfilling their contract to work with us on their issues. They show that they are respecting us and the program and holding up their part of the bargain. When they don't pay, it's a serious problem; they're not respecting the basic contract or the program.
>
> <u>Counselor H:</u>
>
> When I go over the fee with a new client I always talk about how this is their responsibility and our bottom-line. You can't expect to get housing, meals and staff time for nothing. I tell them when they sign over the check they have a say in what happens. It's really the first step in their new life.
>
> <u>Assistant Residence Director D:</u>
>
> Yes the fee is important. It gives them [the clients] dignity and a sense of pride that they are partners in the program. I tell them that I pay my bills each month and they have to do the same. I tell them to feel proud; they're no longer simply living in the shelter; they are at Harlem House and they are paying for it.

It appears, then, that staff have clearly assimilated the agency's concerns regarding fee payments and have gone on to construct strong "therapeutic" rationales for enforcing fee policies. It is little wonder, then, that "deadbeats" are assigned such low social worth.

"Physical Abusers"

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Physically violent clients elicit strong reactions from staff., who view such behavior as a fundamental breach of relationship and the basic social contract of the program. Such clients are understandably at high risk of discharge. First and foremost, staff are understandably concerned about their and other clients' safety.

> Counselor Q:
>
> I will tell you this: when a client is physically violent with us [the staff] or another client it shakes us to the bone. There is nothing as bad; the clients freak and so do we [the staff]. The physical harm, the disrespect, they [the physically violent] just have to go.

Beyond immediate concerns for client and staff safety, L., the Residence Director, described the necessity to maintain a violence-free atmosphere and its crucial role in the therapeutic intent of the program:

> Residence Director A:
>
> Violence incidents are the things that I try to make clear we have the least tolerance of. We work very hard to create a strong feeling that you don't have to look over your shoulder to see who's going to smack you or throw something at you. Only then can you feel safe enough to let your guard down and be nice and even sweet to each other. This kind of atmosphere is a major therapy you can provide in the residence, that people can feel comfortable with each other.

Although staff express this "zero-tolerance" attitude toward physical violence unanimously, as we shall discuss below in the analysis of discharge process and practice, some acts of physical violence do not automatically result in discharge. As suggested by the Hasenfeld theory, there are some mitigating factors which have protected a small number of physically violent clients from immediate discharge. What is key at this definitional stage of analysis is to acknowledge the strongly expressed view of virtually

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all staff that physical violence constitutes a fundamental breech of community norms and warrants discharge.

"Verbal Abusers"

While the staff attitude toward verbally abusive clients is not unanimous, such clients are generally accorded low social worth within the community. Most staff express little tolerance for verbal abuse, whether directed at staff or other clients and view such behavior as a challenge to staff authority and community norms. Cases of verbal abuse that staff felt warranted discharge were typically described by staff:

> Counselor K:
>
> I don't know which was worse, R's cursing out other clients or the way he verbally attacked staff. When he [verbally] attacked M. [a particularly fragile client] staff were really enraged. But, I think the worst was when he went after A. [the Assistant Residence Director]. He called her every name in the book; it was vicious. I knew how she felt because I got it from him too. You feel so disrespected and helpless. When it happens we have to do something. If it's bad, like it was with R., they should go.

This view was echoed by other staff:

> Senior Counselor E:
>
> Verbal abuse is as bad as physically attacking someone. In a way it can be worse. If it's other clients being attacked, well that's over the line. People have to respect each other or how can we get anywhere? When staff are attacked you feel frightened, but you also feel something else: you have to respond, there have to be consequences and they have to be serious enough to try to prevent it from happening again. When it happens over and over with the same client, well I just think they have to be discharged.

Unlike physical violence, however, which staff believe in and of itself justifies discharge, in talking about verbal abuse, some staff express a preference for evaluating

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each instance on a case by case basis. The research found that in instances where serious or threatening verbal abuse is directed at a staff member in combination with other serious rule-breaking, staff view discharge as the appropriate course of action. M. was such a client described by several staff:

Counselor Q:

> M. was my client. She was generally cooperative until one weekend when she went on a drug binge. She spent a lot of money and when we found out about it she was put on restrictions. Since I was the one who reported her, M. got very angry with me for telling. She yelled and cursed me out in the elevator at Portals. She screamed at me and I got very scared. When the staff decided to discharge her I felt grateful and supported.

Clearly, if the client in this case had accepted the restrictions imposed because of the drug episode and had been willing to work with the staff, she probably would not have been discharged. The additional threatening verbal abuse of a staff member on top of the substance abuse episode contributed to the decision to discharge.

"High Boys" and "High Girls"

The staff's attitudes towards client substance abuse went through a significant evolution over the research period. When initial staff interviews were conducted in 1992, staff unanimously cited the residence rules against using drugs or alcohol and saw the breaking of these rules as a primary reason for "negative" discharges. At the time, staff conveyed a "zero-tolerance" policy for drug or alcohol use at the residence.

Senior Counselor D:

> We have rules about drugs and alcohol for a good reason. Clients have their psychiatric problems and drugs and alcohol on top are dangerous and only make their problems worse. Plus, people who use and do crazy things and steal to get money. We've seen it too often;

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> users putting the bite on other clients, even selling the furniture. Plus when they're high you never know what they're going to do, they can lose it real bad. So, inside the residence or outside, it doesn't matter. We can't have it.

Four years later, although drug and alcohol use in the residence were generally seen by staff as justification for discharge, a change in staff attitudes was also apparent. Many staff made a distinction between drug use on-site at the residence, which they continued to see as grounds for discharge, versus drug use outside the residence for which they expressed limited tolerance.

The revised majority view was expressed by several; staff in interviews in late 1996:

> Senior Counselor F:
>
> Using drugs is so widespread everywhere, not just among the mentally ill, and alcohol, of course, is legal, so we've got to see that and somehow acknowledge it. If we said to the clients "if you use drugs or alcohol ever, under any circumstances, then you're out, this would be a pretty empty place." It's never OK in the residence, but if there's a slip outside we can deal with it.

Thus, if the client will acknowledge substance/alcohol use outside the residence and is willing to work with staff to address it, then he or she can remain in the community under a "contract." This most often involves time-limited "restrictions" (e.g., staff holding and budgeting money, being "confined" to the building or escorted outside the building). The client must also agree to attend specialized substance abuse individual and group treatment at Portals.

> Counselor P:
>
> There have been a lot of people we've lost to drugs and I think we felt pretty helpless about it. Now I think we've developed a better way. If

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> someone uses, they either go to detox or treatment. If they are serious about dealing with the problem. we'll know quickly and we'll work with them.

The evolution in thinking about drug and alcohol use clearly reflects an important shift in the meaning that staff attribute to these behaviors. In the early period, staff viewed the issue strictly through the lens of the residence's prescribed rules. Use of drugs and alcohol were forbidden and their use was viewed as a violation of the social contract and their authority. Discharge was "automatic."

In the latter period, the meaning of substance/alcohol abuse to staff changed. Such behaviors were incorporated into the staff's overall diagnostic view of the clients. As such. while flagrant and continuing violations (drug-related physical violence, stealing for drugs. repeated violations with no treatment follow-through etc.) are still seen as justifications for discharge as is on-site use, staff became more willing to view substance/alcohol use as part of the client's overall pathology and therefore something to be "treated," not as automatic grounds for discharge. This clearly meant that staff was more able to view clients individually, that the strict adherence to "rules" could be loosened and that the substance abuse issue achieved "treatment" rather than "disciplinary" status.

> Residence Director A:
>
> What happened was we started to define substance use a part of the client's illness problem, not just as outlawed activity. We began to talk with the clients about telling us (his emphasis) about their slips with the understanding that we wouldn't kill them because they didn't live up to our expectations. This has helped considerably. Clients know that if they slip there are real consequences but if they want to address the substance abuse problem with us we will gladly do it.

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Summary: Negative Discharges 1990 - 1996

To summarize, so far we have identified a number of kinds of clients who rank low on the staff's social worth scale and who are thus vulnerable to negative discharge. These include: the "unengagables" whose behavior frustrates staff, "parasites" who are "ungrateful and over-demanding" of staff time and resources, the "unpredictables" whose behavior engenders fear and frustration and the "blatant rule-breakers" whom staff believe consciously and continually express hostility to them in breaking the community's rules. Sub-categories of "blatant rule-breakers" include "deadbeats" (those who withhold client fees), clients who are either physically or verbally abusive and those who use illegal drugs or alcohol.

As we have seen, there is a strong underlying theme in staff attribution of low social worth to these categories and sub-categories of clients. Staff is seeking gratifying relationships with clients on both professional and personal levels. Clients who are unable or unwilling to establish such relationships are assigned low social worth rankings and are vulnerable to negative discharge. While staff consciously perceive some of the "defects" in their relationships with clients that lead to attribution of low social worth, the process also has a strong unconscious element.

The Negative Discharge Process

As we have seen, the dynamic of assigning low social worth to clients emanates largely from staff's efforts to establish gratifying relationships with them. When this is not possible, a client becomes vulnerable to negative discharge. It is not surprising, then, that more than ninety percent of all negative discharges are initiated by staff. Of the

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twenty negative discharges reviewed for this study only two were initiated by the client. who simply announced his or her intention to leave the residence or simply disappeared.

While low social worth places clients in a vulnerable position. what remains to be understood is the actual process through which clients are targeted for negative discharge. In conducting staff interviews on negative discharges, two important themes emerged: 1) discharges usually take place in a crisis atmosphere, initiated by a variety of specific client behaviors; and 2) there is a norm of staff participation which holds that staff input is always solicited when discharge is contemplated (violation of this norm leads to significant intra-staff conflict).

Thus, the negative discharge process is almost always initiated when a client who was previously assigned low social worth (due to their ungratifying or unsatisfactory relationships with staff) commits a significant act that creates a crisis for the residential community. This is a significant research finding since it appears that low social worth per se is a necessary but not sufficient condition for initiating the discharge process. Low social worth clients are tolerated (sometimes for quite long periods) until they commit a specific act identified as a crisis by staff and clients.

In conducting the interviews, this tolerance was traced to the staff's fundamental attitude toward negative discharge: that it consigns clients to a return to homelessness at worst or at least to a less supportive and nurturing environment. Negatively discharged clients are often seen months later by staff in a variety of negative states – disheveled and riding on the subway. homeless on the street. back in a shelter. It is crucial. then. that staff guilt relating to the discharge is minimized. The commission of a serious act by the

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client with low social worth provides both the immediate justification for discharge and the means of minimizing staff guilt.

The second way in which guilt is minimized and responsibility for discharge is shared is through the discharge process itself. When the client commits an act that precipitates a crisis, a process is initiated through which the discharge is actually carried out. This process, as designed by the residence director, is carefully prescribed and involves all staff. The research found that this participatory model accomplishes three major underlying purposes: 1) it ensures a deliberative process which might easily be short-circuited in the crisis atmosphere of the moment and could lead to a later feelings of regret; 2) it empowers all staff in the process so that individual staff voices will be heard and included in the deliberations; and 3) it makes discharge a collective decision, thereby reducing individual staff guilt. While the residence director was consciously aware of creating both a deliberative and empowering process for staff, the guilt-mitigating function of the process only became clear to him in the course of the interviews.

Staff Perceptions of the Crisis and Deliberative Process:

Feelings are heightened when a client-initiated crisis occurs at the residence. An act of physical violence, serious verbal assault, on-site drug use, stealing from staff or clients or destroying property initiates the process. L., the residence director and two counselors described the process. Note that their descriptions reflect the process themes and purposes just highlighted:

L. the residence director, justifies the participatory process in negative discharges this way:

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Residence Director A:

If you're going to run a residential community you've got to really pay attention to the judgments of the staff as to how a particular individual [client] is impacting on the community. After all, the staff are the people who have to work with the clients. Also, the staff tend to want the director to take responsibility for the decision, but they do want to be heard. I don't want to be out there making decisions that don't come anywhere close to validating people's [staff's] experiences.

The residence director sees a cooling-off period as essential to both good decision-making for the client and creating the opportunity for staff input:

Residence Director A:

A crisis erupts and there has to be a decision made on the spot about how to deal with it. This usually involves staff reporting the incident to the supervisor on duty, who usually contacts me directly. When I'm called, I try to make a decision in a way that has no long-term binding effects. I will not say "he or she is discharged." I will say "he or she can't be in the house now." So we make arrangements for the client, whether it's evaluation at the [psychiatric] emergency room or a move to one of the other residences or even a temporary room at an SRO. This gives us a cooling-off period when the staff can meet to talk over the long-range plan.

Counselors are heavily invested in the participatory process around negative discharges:

Counselor P:

You get caught up in the crisis and calling the police or getting the client out of the residence so everybody's safe. What's good about our process is that L. just doesn't throw people out without having the staff sit down and talk about the client and the incident. You get to plan together and staff's opinions are considered. You can advocate for your client if you want to and you have to hear what everyone else has to say. We make a group decision; you may not always agree but we all are part of it and you respect it.

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A long-time counselor, recalled the earliest discussions with staff about discharges. These occurred during the staff orientation prior to the opening of the residence. She then commented on how discharges were carried out in practice:

> Counselor Q:
>
> At the beginning, L. [the residence director] told us there would be discharges. He explained about the kind of clients we would have and the kinds of problems we would be facing. He also said we would be deciding on discharges together as a staff, that he would ask us what we think.
>
> I have to say that this is what happens. We always meet to discuss the incidents and decide what to do. He (L. the residence director) wants to hear what we have to say. He can be very tough and when he gets that look, you know he's not personally agreeing, but he listens and when a decision is made, if all of us are in agreement that's great; if you don't agree at least it's explained and he listens to your opinions.

A., the assistant residence director echoed the consensus that full staff input into the discharge decision:

> Assistant Residence Director C:
>
> When an incident occurs, really your first thought is to kill. It's human nature and you just want to get rid of the person not only for what they did, but because you're angry at them because you made an investment in them and they messed up. So L.[the residence director] taught us that at that point it's really important to slow things up and remember that our goal is to help people here if we possibly can. At least get past the immediate crisis so that the situation can be discussed and plans can be made. This is the way we try to work.

These concepts – tolerating low social worth clients until a crisis point and following the all-staff deliberative process – were illustrated by several staff in the interviews. Here a counselor describes a case that illustrates power of the process to mitigate individual and collective staff guilt in ordering the discharge:

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Counselor G:

B. had a lot of trouble in the residence from the beginning. It went on for months, questioning his fee and being very hostile. The night of the incident he attacked a staff person who *(sic)* he thought was flirting with his girlfriend [a Harlem House resident]. He just exploded. The next day we found out from M. [the girlfriend] that he attacked her too. At the time of the incident I was on. B. had lost it so badly that before we could do anything he called the police to report D. [the staff member he attacked] for molesting his girlfriend. When the police arrived we talked to them and they took B. to Metropolitan [Hospital psychiatric emergency room]. This was a really bad incident. The clients were scared, I was scared, everybody on staff was scared. B. was kept overnight at Metropolitan so we all felt relieved.

The next day L. [the residence director] called a meeting to discuss the case and someone was sent over to Metropolitan to talk with B. about it. I remember feeling "why are we meeting?" B. has been trouble since day one. There's no way he can come back.

Well the staff decided not to take him back, but we went through the meeting and discussed the incident and reviewed B.'s stay in the residence. The staff member who visited B. in the hospital said that B. was still in a rage, still blaming D. [the staff person he attacked] for what happened. Everybody felt he had to be discharged, but not just because he lost it the night before. It was the whole picture we reviewed. I felt after the meeting that we weren't discharging him just because of one incident, but because it was clear that he never could accept our ways at Harlem House.

The Process Breaks Down

Once socialized to proceed in this fully participatory process, staff reacted very strongly to instances in which they felt their input was not taken into account. The same two instances were sited spontaneously by more than three-quarters of the staff. In these cases, not only were staff angry about not being fully consulted or "heard," they also carried strong feelings about what they viewed as a poor outcome for the clients in question.

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There is a significant contrast between the two cases. In the first, the discharge decision was removed totally from the Harlem House staff: central staff at Portals made the decision. In the second case, staff believed that the residence director made the decision about the course of action on his own, without their input, with very negative results.

Case #1: Crack at the Residence

C. was a female client who was discharged after being caught using crack in the residence. This was at a time when the substance abuse residential discharge policy was being debated both within the Harlem House staff and at a policy level at Portals. In the context of the debate it was unclear exactly what policy would emerge. However, the Portals Director of Housing was enforcing a policy of immediate discharge for any client using illegal drugs in his or her residence.

C. had no history of drug use. The staff at Harlem House believed strongly that she had been lured into the crack episode by another Portals client who was not a Harlem House resident.

Under orders from the Director of Housing (who in turn was responding to Portals administration), the residence director of Harlem House moved to discharge her. According to the Harlem House director this was the only Portals-imposed discharge during his five-year tenure at the residence. He and Harlem House staff resented it, not just because the decision was imposed, but, following the concepts discussed above, because C. was a client who had developed strongly gratifying relationships with staff, who felt tremendous frustration, anger and foreboding about her discharge:

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Residence Director A:

Of course the agency had the right to be concerned about drugs. But we at Harlem House have a responsibility to our community C. had not ever used drugs in all the time she was with us and had no use in her past. She was sacrificed on behalf of a policy that we changed a short time later and I was very upset.

The only way I could sell the discharge to my staff and not have open warfare with administration was that C. made a big show of denying that she actually had used, even when we got back the positive urine. She became very hostile about it so at least I could tell the staff and other clients that there was a serious attitudinal problem and that she wasn't being truthful. Of course the truth wouldn't have done any good anyway. She was a goner; I at least had a little thread of dignity left with the community. But the staff knew we were under orders from Portals.

What was so sad was that C. was just coming into her own. All the hard work was paying off. Staff had developed a really special feeling for her They cared for her and she was becoming one of our important leaders. Staff couldn't get over feeling that one of our really precious people was taken away and that they couldn't do anything about it. The staff meetings went from anger to sad to anger and when J. [a counselor] talked about C.'s life pre-Harlem House and expressed the fear that she might return to it, the entire staff was speechless with frustration and anger.

A counselor remembered the incident angrily:

Counselor H:

What happened with C. was wrong. It was taken out of our hands. We've got to make our own decisions; we're professionals and know the clients best. Sure C. was a handful; she could be hostile and difficult. But she had moved so far forward in the first year. She was no angel, but she improved so much that she won us over. When I first heard about the incident I thought we would be able to work it out with her. When I realized that she would have to go, my heart went out to her.

I don't think that L. [the residence director] agreed with the discharge either. His heart wasn't in it. I thought he was probably as upset as the rest of us.

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Subsequent events in the same case illustrate the staff's sensitivity to being excluded from the process. After C. left the residence, the residence director and her case manager in the Portals day treatment program continued to challenge the discharge. C. was permitted to continue in the day program and joined one of the substance abuse treatment groups. Several months later, after the new agency policy was adopted that no longer required immediate discharge for substance use in residence, C. was readmitted to Harlem House.

The readmission (orchestrated by the residence director) was somewhat controversial among some Harlem House staff, who again felt they had not be consulted. Two counselors summed up their feelings:

> Counselor J:
>
> C. came back and right away she was doing a lot better. She was cooperative and ready to work with staff. I was happy to see her back, but the problem was that we didn't know she was coming back. Staff wasn't consulted; we were told she'll be back next week. L. [the residence director] said, "We decided to take her back." I was happy but I laughed to myself, "Like hell we did; you did."
>
> Counselor I:
>
> Staff never talked about C. returning. Although she had become better, I remember the months when she was lazy and gave me a hard time. I shared my feelings with the staff in a meeting, but L. [the residence director] wasn't there. He made the decision on his own to take her back. He certainly didn't talk to us. I thought, great, she's out of the SRO, but should she be back here?

Clearly, both counselors expected to be consulted about the readmission and resented the residence director's unilateral decision. The second counselor's criticism

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illustrates that consultation was a more important value than rescuing the client from the poor circumstances of SRO living.

Case #2: Staff vs. The Residence Director

The case of S. was described by all staff as a unique example of conflict between them and the residence director. Although not technically a "negative" discharge because S.'s pregnancy and childbirth necessitated her discharge since Harlem House does not serve mothers with children, it certainly was "negative" from the staff's perspective, except to the residence director. While the discharge was a foregone conclusion, the process was highly problematic. Staff believed that the residence director blocked their efforts to assist S. when she needed it the most.

This is a case in which a client's highly gratifying relationships with staff were in conflict with the professional judgment of the residence director. While all staff acknowledged doubts about the client's ability to adequately care for an infant, the residence director clearly acted on his belief that the pregnancy should have been terminated or that the client should have agreed to give up the child for adoption. His unwillingness to allow the staff to "help" confused and infuriated them. For their part, staff could not understand why the residence director would not allow them to provide assistance to such a highly regarded client.

> Counselor P:
>
> S. was with us for about two years. She came in pretty bad, with poor functioning and very confused. She was sexually aggressive with male staff and had a lot of sexual relationships with male clients. She got better over time and we all got to like her; she had this childlike quality

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people responded to...S. started talking about wanting to see more of her son [four years old] who was in foster care. The staff supported this idea and we arranged visits at the residence. Shortly after this S. started saying she wanted to have another baby because "the government took away the first one." She talked to the staff as well as to L. [the residence director] about getting pregnant and was counseled not to. She got pregnant anyway by the same man who was the father of her first child and L. [the residence director] was furious. Well, next we encouraged her to have an abortion, but she refused.

That's when the staff problems started. The foster care agency that was working with S.'s son said they would help with hospital care and setting up an apartment if Portals gave them a letter saying that S. was competent to raise the two children. Staff got very angry when L. [the residence director] and Portals refused to do this. It was the same time we were helping F. set up an apartment to get back her child from foster care and staff couldn't see why we were helping F. and not S.

I would see S. with her son during the visits at Harlem House and I knew it would be a struggle for her to raise a child. When her son visited, S. either took a nap or just left him there by himself, uninvolved. She had a fantasy about raising the two kids but she never could. So I understood L.'s position, his concern was for the baby and what would happen if it didn't work out, which I didn't think they would.

But, S. still needed our help with benefits and finding a program that works with mentally ill mothers. We would have found <u>something</u> [his emphasis] for her, but L. shut down. He wouldn't let us help and we were fuming.

Staff meetings on this case were bitter:

<u>Counselor H:</u>

The staff meetings were unbelievably tense; I never felt that way before. L. [the residence director] said that if we encourage S. by helping her then we're making it easier for her to keep the baby and this would be a total disaster. Staff agreed with this, <u>but</u> [his emphasis] there was still no plan for S. You couldn't even bring it up with L. though; it was just <u>no</u>, that's how angry he was. He wouldn't discuss it.

<u>Counselor G:</u>

The hardest question I ever had to answer at Harlem House was when S.

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> asked me, "Why won't Portals help me?" We got a team together to help. We wanted to present the list of services to L. I agreed to present it at the staff meeting. I didn't get ten seconds into my speech and L. said, "No, we're not going to discuss it."

Events after S. was discharged somewhat ameliorated the morale problems that several staff members identified around this case. Just before delivering, with the residence director's approval; a plan was made for S. to move to a shelter that serves mothers and children, although the program did not offer the kind of supervision and mental health services that S. needed. After the birth of the baby, S. began to visit Harlem House regularly, raising staff anxiety further, although confirming the residence director's fear.

The counselor who worked most directly with S. at the residence, recalled these visits:

> Counselor K:
>
> After the baby was born S. brought her here to visit every weekend. It was scary. She had no patience for the baby. She was constantly putting it in a dangerous situation. I know this is what L. was worried about.
>
> After a few weeks I realized S. was acting like an animal – no worse. I saw her throw the baby into a chair. She was either distant from the baby or angry at it.

Ultimately, staff contacted child abuse authorities:

> Assistant Residence Director D:
>
> It was during the visits that we knew we had to act. One time S. threw the baby's clothes on the floor and the baby showed up with dried milk all over her face. S. said she couldn't get it off. That's when we called the [child abuse and neglect] hot line. We couldn't believe that the shelter wasn't doing anything and we all thought that S. was not taking her medication. So we called CWA [subsequently NYC Administration for Children's Services] and got some action.

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Thus. the staff's contact with the client following her discharge somewhat vindicated the residence director's actions during the pregnancy. although staff continued to feel resentment toward him.

Summary: The Negative Discharge Process

The concepts of social worth and staff/client relationships are woven throughout the negative discharge process at Harlem House. Staff is faced with an enormous challenge in discharging low social worth clients, stemming from their belief that such discharges will lead to client psychiatric deterioration and, more than likely, the resumption of homelessness. Given this meaning to the staff, such discharges always trigger guilt feelings among staff. The mitigation of these feelings is a significant task for staff to accomplish in the negative discharge process.

Given the potential for staff guilt, the research found that staff will often tolerate low social worth clients until they create a "crisis" that requires immediate attention and staff action. Such crises almost always involve physical violence, threatening verbal abuse, destruction of property or flagrant violations of the substance abuse policy.

By design, the discharge process involves all staff in a fully participatory manner. Through a structured deliberative process, the crisis atmosphere is stabilized and staff have an opportunity to review the client's overall status in the program. Usually, a consensus on discharge follows these deliberations. As we have seen, staff highly value this process in which they feel they provide meaningful input. A strong consensus following a deliberative review mitigates guilt feelings.

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Two case examples of staff discord were presented to highlight the value that staff attribute to the participatory process. While the process provides a significant opportunity for staff to mitigate guilt and feel empowered in crucial decision-making, there are times when the feelings of staff entitlement come into conflict either with external forces at Portals or, internally, in staff dissension. Clearly, when staff expect effective participation (and require it more unconsciously to mitigate guilt feelings), their morale is especially vulnerable if they perceive that senior residential staff or the agency are not responding to their needs.

The Aftermath of Negative Discharge

Client Participation and Reaction

As described above, the negative discharge process usually occurs in response to a crisis created by a specific client behavior, albeit that this is often at the end of a long chain of events during which the client has been assigned low social worth by staff. We now turn to the staff perception of the role of other clients in the residence in the negative discharge process of their fellow clients.

The research in this area revealed a consistent pattern of client involvement: 1) organized client demands to have a fellow client discharged from Harlem House are extremely rare; 2) clients with serious complaints about a fellow client are more likely to share their concerns in one-to-one discussions with staff, not in community meetings; 3) the crisis atmosphere that surrounds most discharges often results in a muted client response in which, according to staff, clients usually perceive the staff's anger and frustration with the discharged client and are not willing to challenge the staff decision.

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perhaps fearing their own vulnerability to future discharge; and 4) there is often a series of delayed reactions in which some clients seem to go on "good behavior," while others express escalating feelings of concern for the discharged client.

The common thread in this pattern of involvement is the clients' sense of vulnerability in the residence. Staff share this concern, often viewing discharge in "life or death" terms. Since negative discharge often entails loss of housing, returning to homelessness or resuming the downward spiral of psychiatric hospitalizations and uncontrolled substance abuse, clients have considerable fear of the possibility that they might be removed from the residence, and, as we have seen, staff have the "burden of guilt" to contend with. These mutual staff-client issues have a profound effect on relationships between clients and staff in general, as well as their reactions to individual negative discharges.

Client Initiation of the Negative Discharge Process

According to staff, then, organized and concerted action by clients to have a fellow client discharged are rare. This is not surprising given the meaning of discharge to clients and staff alike. The residence director and a counselor commented on this phenomenon:

> Residence Director A:
>
> Clients do absolutely horrendous things and yet the other clients won't take up the battle cry to discharge them. The message they seem to be giving to staff is: "Are you sure you're doing everything you can do to keep so-and-so in line and in the residence? It's pretty rough out in the streets. I was there."
>
> Counselor M:

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> The only time I can actually remember clients actually advocating for the discharge of another client publicly [in the community meeting] is when it's clear that the staff [emphasis added] has made up their mind about someone leaving after a big blowout. Usually, the person who caused the trouble is not at the meeting, and even then it feels like the other clients are going along with what they think the staff has actually decided. I think the clients have a kind of unspoken pact with each other: no making trouble for other clients, at least not in the community meeting.

When clients express their negative feelings about fellow clients it is usually in private meetings with their counselor or a member of the senior staff. Although staff indicated that this does not happen often, when it does occur, client expressions can be effective:

> Counselor P:
>
> While I've never seen a client call for someone's discharge at the community meeting, a couple have come to me individually or they'll talk to L. [residence director], A. [assistant residence director] or D. [senior counselor] directly. These individual meetings are in the form of complaint, I don't think I've ever heard a client directly ask for someone to be sent away.
>
> There was a client, K., where it got as close as I've seen to an organized [client] campaign, though it wasn't really organized. Everyone was afraid of K. and there were so many incidents. Clients would talk to their counselors or senior staff about it and they [put a lot of pressure on staff to do something. I think that the client's feelings were an important part of K.'s discharge because there were still advocates on the staff at the end.
>
> Counselor Q:
>
> You don't see the clients rise up against someone, except when they're part of a big incident, and usually after they cool down they don't pursue it. But in the case of K.'s discharge I thought it was different -- the clients were insistent and caught the staff between a rock and a hard place.

Immediate Client Reactions to Negative Discharge

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Staff reported a consistent pattern of client reactions to negative discharge, reflecting their abiding sense of vulnerability described above, as well as their sense that challenging discharges after the fact would be futile and might anger staff. Since there are daily community meetings at Harlem House, when a discharge occurs, it becomes an immediate topic of discussion. In the meeting the incident and discharge process are reviewed and clients and staff share their reactions.

Staff describe these meetings as low-key and tense. Often, the incident that led to the discharge was witnessed by or involved other clients. But, there is often little discussion. Staff described this phenomenon and suggested an explanation:

> Counselor H:
>
> At the community meeting after a discharge the clients are usually into themselves. I used to think maybe they're in a state of shock. But I've come to realize that they're in a pretty uncomfortable place. The staff has already made the decision so I think they're either afraid to challenge staff or feel they can't do anything about it anyway. And, you know, clients have the fear [emphasis hers] in the back of their minds: the last thing they would want to do is question the discharge.
>
> Counselor I:
>
> The first time I was involved in a negative discharge I was very surprised at the way the other clients reacted. The meeting was very quiet and even though I knew people had strong feelings, hardly anybody spoke. L. [the residence director] reviewed what happened and some staff joined in. But clients didn't question what the staff had done even though G. [the discharged client] was very popular. Even the clients who saw what happened [the discharged client had gone into a rage directed at one of the male counselors and shoved him] didn't say much.
>
> I think that clients are afraid to say anything. I don't know if they feel powerless, relieved, or angry. Most times they don't say.

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There is one client, however, whose role in these meetings staff liken to "the conscience" of Harlem House. S. is a middle-aged woman who has been in the residence since it opened. At community meetings following a discharge, S. invariably raises concerns about it, no matter how flagrant the incident may have been. With S. assuming this role, staff believe that other clients feel relieved of the responsibility to challenge staff:

> Counselor M:
>
> You can always count on S. to defend whoever is being discharged and to express fears about what will happen to the person now. She's worried about people ending up back on the streets, no matter how bad they behaved at Harlem House. She always lays this out at the community meeting; everyone expects it and I think the others [clients] count on her to express their fears.
>
> Counselor Q:
>
> S. says what a lot of other people are thinking. L. [residence director] will turn to other clients and ask their opinions, but most times he doesn't get much response. S. kind of says it all. Sometimes the other clients will kind of laugh at S., but the truth is she speaks out for them.

Individual Client Outreach and the Delayed Client Reaction

While many clients might not be willing to speak up in the community meting, they often express concern individually to staff or other clients:

> Counselor I:
>
> When K. was discharged I think that most of the clients were relieved at first. You know, it had just become too much. At the community meeting all the clients seemed to go along with it, except of course S. Bu later that day I saw some clients get together in a little huddle. I know they were talking about K. Over the next few days, several clients singled out staff to express concern about K.'s future.
>
> Counselor J:

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> Oh, sure the clients care [about whoever is discharged]. They might not show it in the group, but they will talk to each other and their counselor or maybe one of the senior staff about it. Most of the time it's a delayed reaction. A few days and even weeks might go by and they'll bring it up. They are concerned, even about the ones they were scared of or didn't like.

This kind of delayed expression of concern appears to be part of the pattern identified universally by staff. It clearly reflects fears about being "next" and what that would mean. Here we encounter the allusions to "life and death" and the terror of being "back out there:" In using these terms staff not only reveal how they believe clients perceive discharge, they also reveal the meaning that negative discharge has for themselves:

> Counselor K:
>
> You see it all the time after a discharge. Clients really worry that they could be "next." So you get this mini-honeymoon where they're on very [his emphasis] good behavior. I think we all feel this when it happens. It's a combination of "Thank God it wasn't me" and "Oh, my God, it could be me next week."
>
> Counselor Q:
>
> The clients usually get very quite and extra cooperative after a discharge. You can tell they're thinking, "There but for the grace of God go I." It's being "next" that they're so afraid of.
>
> Counselor G:
>
> I agree that clients get scared, even when someone is discharged to an obvious violation. The clients take it as a lesson and they have a lot of fear. "Maybe I'll be the next person leaving." At these times clients feel that at any moment they could lose it all and they would be facing the street.

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Staff Reaction to Negative Discharge

Staff reaction to negative discharge is clearly infused with their sense of doom that this outcome represents to them. They clearly believe that the services provided at Harlem House are unique and that negatively discharged clients are condemned to the resumption of the chaotic lives they were leading before admission to the program. (There is some reality to these feelings; there are very few twenty-four hour supervised residential programs for the mentally ill homeless). The staff justifies these feelings with many examples of the "failures" of negatively discharged clients, describing post-discharge contacts with them directly or "sightings" of them in deteriorated condition. Thus, as we have seen, not only are staff slow in initiating discharge, they must view the discharge as being largely the client's responsibility, lest they be overwhelmed by their own guilt feelings.

The Meaning of Negative Discharge to Staff

The staff's beliefs about the uniqueness of Harlem House and the meaning that negative discharge has for them was described universally:

> Assistant Residence Director C:
>
> Sometimes I shake inside when I think about what is going to happen to some of the clients we discharge. There is just no place to discharge to with the kind of support and services our clients have here. So, even though I get angry and I know that certain people have to go, I still feel awful. When they leave here it's almost always for worse.
>
> Counselor L:
>
> Our clients need so much attention and they get it from us. But there's nothing like Harlem House out there, or if there is I don't know about it. I

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picture some of the people who have left and I know they can't make it without us. It makes me sick to think about it.

Senior Counselor D:

I usually want everyone to stay and get better and I know that's my rep[utation]. But when you think about it, where are they going to end up when they leave? I haven't seen anything that comes close to the kind of job we do here.

Client Responsibility

When discussing specific cases, then, the research revealed a strong need among staff to assign the responsibility for negative discharge to the client. This approach provides staff with the rationale for the discharge consistent with their professional values while relieving staff guilt. The residence director lays the groundwork for the idea of client responsibility in the earliest stages of admitting new clients to the program. In emphasizing client responsibility "from the beginning," the residence director not only clarifies a crucial issue for new clients, he is also establishing the concept of client responsibility for negative discharge:

Residence Director A:

The clearest statement I try to make and have staff make to new clients is: here is the way we operate at Harlem House, here are the rules and if you are willing to work things out we will work with you. You will discharge yourself here if you don't follow this plan. The things that bring about discharge are totally in your control [emphasis added].

Client "irresponsibility," then, what staff view as the unwillingness of clients to regulate their behavior, is an important concept adopted by staff in initiating or accepting negative

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discharges. Again, this reflects a focus on the client's behavior, not the psychopathology that might give rise to it.

> Residence Director A:
>
> ...When you're about to get consumed with guilt about discharging someone who was homeless into another bad situation, sometimes I say to myself very crassly, "Now we see why they were homeless originally." We didn't put them in the streets. There are some really dysfunctional people who don't do any better in the community than in long-term hospitalization. It can't be our goal to have everybody in the community. And if, in fact, all you do is hurt or disrupt others, then you can't be in this community. For you the "least restrictive" setting would be replaced with the "most appropriate setting": a hospital or someplace else.

In practice, staff often apply the concept of client responsibility to those negatively discharge clients who they believe are unwilling to be held accountable for their own behavior.

> Counselor H:
>
> R. had to help himself. We made so many efforts to work with him. There is nothing more Portals or anyone else could do. He wasn't buying it.
>
> Assistant Residence Director C:
>
> Staff was O.K. with J's discharge. We got fed up with him. He was manipulating us and lying constantly. We tried, but he wouldn't respond... He wouldn't take responsibility for his actions. We would warn him and point this out to him, but he just wouldn't respond.
>
> Counselor L:
>
> When we discussed whether or not we should discharge G., I expressed my feeling that nobody could work with him. He thought that he could do what he wanted to do and that was that. Everyone agreed; nobody [on staff] advocated for him. The last thing G. wanted was to work with us.

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In instances where staff justify a discharge in this way, as a "responsible" client who is unwilling to accept responsibility or accountability for their actions while rejecting staff efforts, the underlying staff emotion is clearly anger toward the client:

> Counselor P:
>
> To tell you the truth I was really angry at J. and everybody else [on staff] was too. It's not that he couldn't; it's that he wouldn't (emphasis hers).
>
> Counselor J:
>
> I was so pissed off at G. I couldn't believe we [the staff] sat and talked about any other option than discharge. You know, help comes to those who help themselves. My heart was pounding and I felt heat rising up my neck. Thank God everyone agreed that she should be put in the hotel. I'm not sure I could have kept my cool.
>
> Counselor M:
>
> D. was bad news and as far as I was concerned it was good-bye and good riddance. I don't think I was ever so angry at a client as I was at D.

Staff Response to the Negative Discharge of High Social Worth Clients

Negatively discharged clients who had previously enjoyed high social worth by establishing gratifying relationships with staff, elicit a different kind of staff response following discharge. While initially staff express strong anger toward such clients (clearly reflecting their strong sense of betrayal and frustration in "losing" clients whom they previously valued highly), a different mid-range reaction was evident after a relatively short time period (one to two months). In contrast to staff reaction toward negative discharge of low social worth clients, which remains infused with anger and the strong sense of client responsibility just described, staff respond to previously higher social worth clients with considerably more forgiveness and concern. Here, in the mid-

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and long-range, the client is not held as personally responsible, anger becomes muted and expressions of guilt or helplessness emerge more noticeably:

> Counselor K:
>
> ...Take the case of V. She's another one. We [the staff] were really close to her for so long. You know how much she needs us and now she's out in the streets and it's going to be trouble. So it's really hard, the guilt you feel, especially since she came so far and did so well for so long. You try to keep your distance – you're supposed to have doctor's neutrality – but it's very difficult to do sometimes, especially for the ones you cared about so much.
>
> Counselor G:
>
> When J. was discharged I was really upset. She was at Portals for years, even before Harlem House opened. We [staff] would talk about how to stop her slide – it was drugs and she couldn't stop. She wouldn't accept detox or treatment and I knew if she wouldn't do it for herself or us she probably had to go back to the streets and hit bottom again. But I wondered if there wasn't something else we could try. I felt this helpless feeling; the whole staff did.
>
> Counselor P:
>
> It was so hard to accept L.'s discharge even though I knew it was getting totally out of hand. When the incidents started happening more often, we hoped that adjusting his medication would help and we all talked with him constantly. But things just got worse and no one could come up with any other solution. Yes, we had to do it, but I didn't feel good about it. We couldn't find a way to deal with his anger.

A variation of this reaction to discharging previously high social worth clients involves rationalizing the discharge as somehow beneficial to the client from a professional perspective. As extra protection from the anger and guilt that accompany such discharges, staff often describe them using uncharacteristic sounding "professional" jargon. The use of similar-sounding language by different staff indicates that there has

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been much staff discussion and "processing" of the discharge. The discharge of L. is an example:

> <u>Counselor Q:</u>
>
> I think in the end that the residence was too stimulating for L. He needed something quieter where he wouldn't be so stimulated.
>
> <u>Counselor I:</u>
>
> There's no doubt that Harlem House was too stimulating for L. The pressure of all the relationships was too much for him. It was best for him to move out.
>
> <u>Counselor G:</u>
>
> L. couldn't handle all the pressure of the relationships in the residence. You know he's really very limited in trying to process everything. It was just too stimulating for him.

A final category of staff reactions to negative discharge of clients, whether previously held in high esteem or not, might be labeled "resignation and naïve hopefulness." Here some staff seem to minimize their guilt feelings by either feeling a simple hope that clients will "make their way" successfully in the community or that some clients have a <u>preference</u> for street life that they have a right to exercise:

> <u>Senior Counselor F:</u>
>
> Homelessness is a physical way of life for some people in America. The clients that come through here, many of them are moving from program to program, not just staying in the streets. I kind of feel that although they leave here, they're not just homeless. They're in another program somewhere, and I feel kind of good about that.
>
> <u>Counselor K:</u>
>
> I hope that people who leave here will be able to find something. If they go through bad times and end up in the hospital, then I'm sure they'll get

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another chance with some other program. It won't be as good as ours, but at least it will be something.

Counselor Q:

If people did it once [found a program] then they'll probably be able to do it again. So I don't feel too let down. I'm sure a lot of people we've discharged will make a new connection and by O.K.

Staff Contact with Clients Following Negative Discharge

The differential social worth accorded clients by staff is also evident in their actions following discharge. The research found a surprisingly large amount of staff contact with discharged clients (much was of an inadvertent nature, such as spotting people on the subway or street). In terms of purposeful contact, clearly the amount of contact and staff outreach to previously discharges clients varies directly with their social worth ranking. In the case of low social worth clients, staff usually express "good riddance" and have minimal contact. On the other hand, when previously recognized high social worth clients are negatively discharged, staff often take a direct interest in their community adjustment:

Senior Counselor D:

...There are no good discharges. But there is a big difference, very often, in what we do for people. After we calm down, you know the ones we care about we reach out to and stay in touch with. We check up on some people for many weeks, even months after they leave.

Counselor J (comparing discharges of previously low and high social worth clients):

Those discharges were like day and night. In the case of D. and E. it was good-bye and good riddance. Staff was happy to just have them out and slam the door behind. But take L. for example. Right away staff expressed concern about putting him in an SRO, even though we knew he had to go. For the time he was in the SRO me and J. [another counselor]

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would bring his medication over there. And then we all pitched in to make a better plan and found the VOA [Volunteers of America] program.

Counselor P:

At the [staff] meeting we talked about C. He was doing well for so long, the staff felt bad about discharging him. So we agreed that if C. could be transferred to another Portals residence or the apartment program this would be best. Staff was too upset at the idea of putting him in a hotel. We worked on this plan and felt better when he moved to Second Street [another Portals residence].

Chapter Summary

In this chapter we have seen the workings of social worth attribution as they play out in the negative discharge process at Harlem House. The key concepts that emerged in the exploration of negative discharge are illustrated in Figure 2 on the next page.

We began by exploring the categories and subcategories of low social worth clients who are vulnerable to negative discharge. Next, we examined the discharge process, finding that low social worth, in and of itself, is not solely implicated in the discharge process, but that it must be combined with a specific set of client behaviors that create a "crisis" which is then addressed through discharge. The crisis is apparently necessary in order to mitigate staff's potential guilt feelings, which are traced to their beliefs that once discharged, clients are likely to deteriorate without the services they need.

The discharge process, which involves the full participation of all staff, is clearly designed to share responsibility and lessen the burden of guilt. Case examples of staff consensus on discharge were presented along with two instances of staff conflict.

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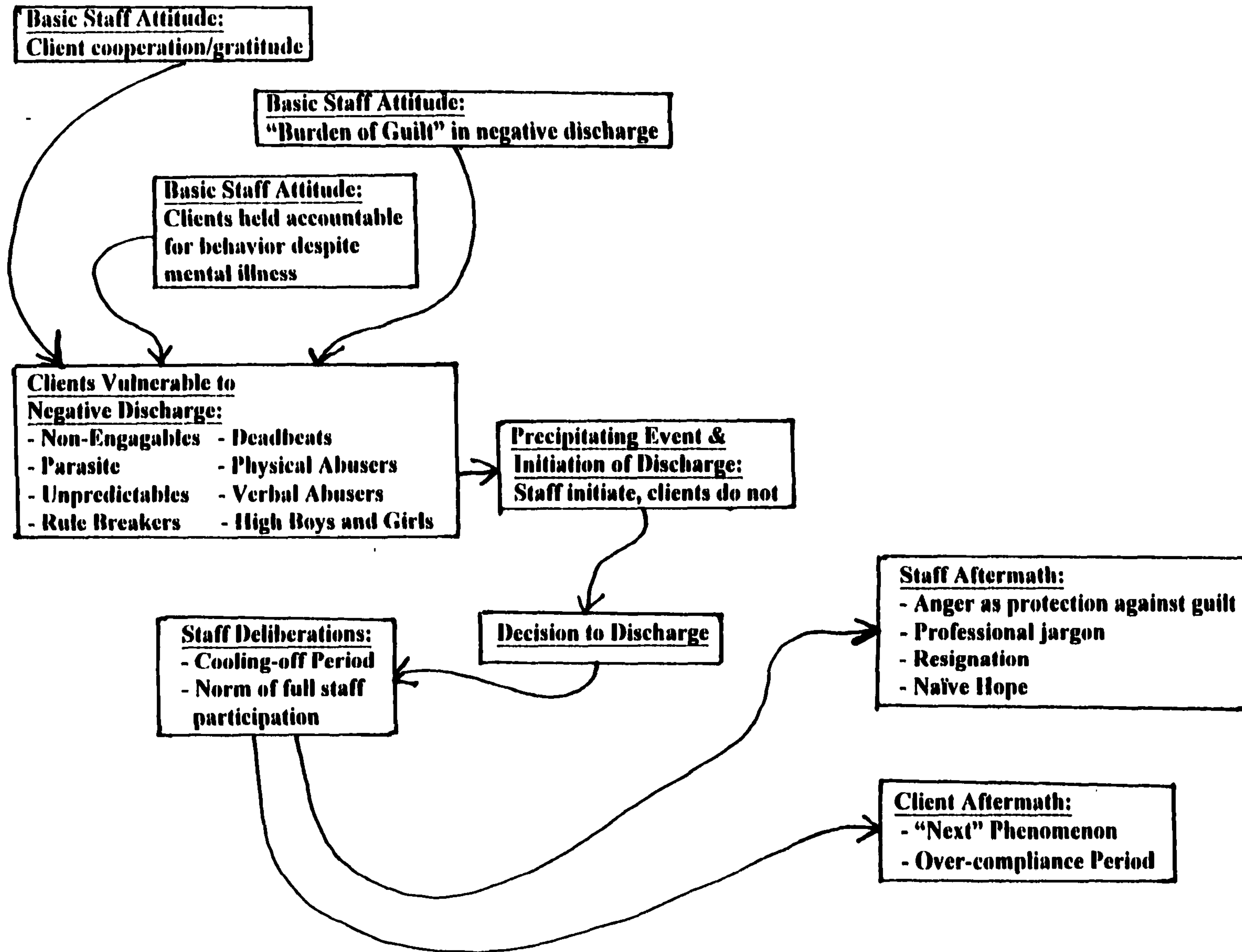
Figure 2. Negative Discharge



We next examined the reaction of clients who remain in the residence to the negative discharge of other clients. Staff reported universally the belief that client reaction to negative discharge is shaped largely by what staff characterizes as the clients' concerns about their own potential vulnerability to discharge, fears of being "next." Clients rarely challenge the staff decision to discharge and never do so "publicly." They may express concerns "privately" to individual staff members.

Finally, we examined staff reactions to negative discharge, again tracing core attitudes to the potential "burden of guilt" that must be mitigated in the process. Staff react to negative discharge with considerable immediate anger directed at the client and view discharged clients as being responsible for their own fate. Staff may also rationalize discharge with professional jargon or they might simply express feelings of resignation and a naïve hope that clients will fare well after leaving the residence. Staff have minimal follow-up contacts with low social worth clients, although inadvertent contacts usually confirm for staff that the client has indeed deteriorated since discharge. In the case of previously designated high social worth clients, staff's anger around negative discharge often dissipates relatively quickly and staff make significant efforts to maintain contact and provide assistance.

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CHAPTER 7

Positive Discharges and the Discharge Process

Introduction

In examining "positive" discharges from Harlem House, (defined as clients moving, with staff agreement and support to less supervised, more independent housing, returning to live with family, etc), the research found a significant shift in policy and practice over the six-year study period. In the first four years of operations (1990-1994), there were a relatively small number of such discharges (four, as compared to twenty-three negative discharges). In all four cases, the discharge was initiated by the client and required him or her to overcome considerable staff "resistance."

In 1995 and 1996, however, the discharge pattern changed dramatically. In these years, Portals established a permanent "graduate" housing program of its own and was under both internal and external pressure to fill these new beds. As predicted by Hasenfeld's theory, when the agency's "political and economic needs" changed, the calculation of social worth changed also. Thus, although the cultural and normative context of practice was just beginning to change (i.e., the staff valuing the new concept of "graduate" housing), the research found that the external pressure from the State Office of Mental Health and the internal pressure from agency management accounted for the large number of "positive" discharges to Portals "graduate" housing in these years.

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This chapter will examine the positive discharges over the life of the residence, the processes through which clients were selected, how the discharges were accomplished and their impact on clients and staff.

"Positive" Discharges and Discharge Process 1990-1994

Client Motivation Overcoming Staff Resistance: "What if...?"

Diagnostically, the four "positively" discharged clients during this period were similar to other Harlem House clients. All had major Axis I mental illness diagnoses, with (as we shall see below) severe pathological features. In reviewing the discharges with staff, all agreed that what set these clients apart was their persistence and self-motivation in pursuing their self-generated goal to move on from the residence. That is, in each instance, the idea of pursuing more independent housing came from the client, not from the staff. And, each of the clients had to persistently overcome considerable staff doubts in order to succeed with the discharge.

Thus, despite the fact that Harlem House is by definition a transitional program whose major objective is to prepare clients for more independent housing, during the first four years of the residence's operations, staff did not identify any clients for "positive" discharge. Clearly, at this time, staff did not automatically confer high social worth on clients who expressed interest in positive transition. If anything, staff resistance reflects their strong preference to have clients, even those who expressed a concrete desire to move more quickly through a planned, positive discharge process, remain in the residence, where staff placed the highest value on participation in what staff perceive to be mutually gratifying relationships.

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In exploring this phenomenon, staff unanimously traced their own "resistant" attitude to a fundamental concern for the clients' welfare. In conducting the interviews, the researcher dubbed this the "what if..." factor: staff discouraging clients from moving forward by warning them of the dangers that awaited them outside the program. On a conscious level, staff viewed Harlem House as a unique, nurturing and necessary program for its clients, without which they would be doomed to certain psychiatric deterioration and homelessness.

> Senior Counselor D:
>
> Usually I feel, how can they seriously think about leaving Harlem House? They'll never get the kind of support and services they need, not even in another program. They're really better off here, you know.
>
> Counselor P:
>
> A lot of people say they want to live independently, but I always discuss with them how hard it is. Basically, here you do a lot of things for them. I ask them: "Will you be able to do these things on your own? What if you stop taking your medicine or if you get anxious or depressed? What if you miss an appointment at Medicaid or SSI? What if you get a job and then lose it? What if you can't pay the rent?" I try to get them to see these things and that it's really tough out there.

Thus, from the relationship perspective explored in Chapter 6 on negative discharges, we see that staff, having formed gratifying relationships with clients, were reluctant to allow them to leave the program. While their concern for client welfare is both admirable and justifiable to a degree (at the time there were indeed few support structures in place for the more independently housed mentally ill), the fact that staff did not identify any clients for positive discharge during this period, seems to reflect a paternalistic attitude and clear message to clients that, once successfully inducted into the

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Harlem House community, they were expected to remain indefinitely. (As we shall see in Chapter 8 a second largely unconscious process is also at work. Clients who assume roles that staff value highly are also assigned high social worth and expected to remain in residence indefinitely).

Whether traced to paternalistic staff attitudes or the more subtle reality of staff dependence on some clients for material and psychological gratification, the fact remains that staff, in the period 1990-1994, did not inform clients of the transitional nature of the program and their expected "graduation" to more independent housing. All clients reported that, during these years, even at the time of their admission to the program, they were not told that Harlem House was a transitional residence, with a limited length of stay. It is little wonder then, that clients who sought positive discharge at this time had to be highly motivated to overcome the staff's resistant attitudes. Such clients were both self-selected and had to expend considerable energy to convince staff of their serious intent.

The three examples below illustrate this process during this period. In each instance, the client initiated the discharge process and staff reacted with skepticism. In order to succeed with the discharge, each client had to convince staff of his/her seriousness about discharge and demonstrate the ability to live more independently, despite their obviously serious pathology. Clearly what set these clients apart was their persistence in the face of considerable staff resistance.

K. was a 43-year old client who was an immigrant from Eastern Europe. She was referred to Harlem House from a women's shelter where she had resided for more than

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three years. She was diagnosed with schizophrenia, paranoid type. When she announced her interest in moving on, staff expressed skepticism which lasted to the point of discharge.

> <u>Senior Counselor D:</u>
>
> K. was bizarre. Initially, she had very poor relations with clients, partly because of her problems with English, but also because she was very paranoid and could only focus on herself in conversation. During her time at Harlem House she developed some relationships with clients and she always did O.K. with staff.
>
> She talked a great deal about wanting to be more independent, going to school and having independent housing. She didn't like having three roommates and wanted her own place. When staff first talked about it, no one thought this was a good plan. K. was simply too bizarre. She had trouble taking her meds and her room was a pretty big disaster. But, she didn't let it drop. She was in everybody's [staff's] face about it. So finally, at a staff meeting, L. [the residence director] suggested that we come up with a list of goals she would have to achieve if she wanted to move to a Portals apartment.
>
> I thought, this is crazy she'll never do it. But K. worked on her goals hard; she was determined and I started to realize she wouldn't stop until she succeeded. When all the short-term goals were met [being able to take medication independently, being able to self-travel and being able to budget] we got her into a Portals apartment. We thought, she's strange but she did everything we asked. Sometime I think she did it despite us. And even though she did everything I still thought she wouldn't be able to make it. My fingers were crossed but in the pit of my stomach I thought this would be trouble.

D., a 36-year old male client was well-liked by clients and staff. His plan to move on was also met with staff resistance. A highly delusional client, who had lived in a subway tunnel for several years, his case illustrates both how each "positively" discharged client set his/her own discharge goals and how they had to persevere in achieving them.

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Counselor K:

D. had all those crazy ideas, about writing songs on the radio and collecting royalties. He was endearing though, and the clients and staff liked him a lot because he could be funny and have a good time.

The thing was that D. always wanted to leave Harlem House; he complained about some things like paying the fee. But he cooperated even though he disagreed. It was his idea to move out. One day he went on a trip with a group to a state park and liked it and talked about how he was raised on a farm (we didn't know if this was true) and wanted to move back to one. We [staff] thought this was weird. No one could picture him in that kind of place. But he persisted and after a few of months we found him a boarding home on a farm upstate. It was his idea from start to finish.

Assistant Residence Director C:

All D. talked about was his wanting to leave the city. He said he felt unsafe and would point out the crack dealers and gunshot holes. He insisted on the country, which I didn't take seriously at first. I set up some appointments for him at places in Queens and Brooklyn, but he rejected them. When he came back from visiting the farm for the first time he had a big smile on his face. He said it was perfect. So many clients talk about moving on; D. said it and meant it.

F. was a third positively discharged client. She was in her late thirties and became very focussed on the goal of regaining custody of her teenage child and moving to independent housing. F. was diagnosed with bi-polar disorder and substance abuse. She had a long history of hospitalizations and homelessness. During her first year at Harlem House she had a difficult adjustment. Medication compliance was a major issue and she was aloof from the community. In her second year, as her condition stabilized, she became more cooperative, although largely in pursuit of her own goals. She remained uncooperative in doing kitchen chores and in meeting with her counselor for scheduled

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daily living skills sessions. During the second year, staff recall that F. began to talk about leaving the residence, gaining custody of her child and living independently.

In overcoming resistance to her discharge, F. created a rift within the staff. Some remained opposed to the plan, both because they felt she didn't merit their special efforts in light of her uncooperative attitude in some areas (i.e., not doing kitchen chores) and because they were concerned about whether she could live successfully with her son independently. In the end, by winning over the residence director, F. obtained enough staff support to carry through her plan.

> Counselor H:
>
> Talk about determination! F wanted her kid back and it's all she talked about. Now at first it was mostly talk and no action and in the end she had what I would call "cold feet syndrome." But in between, she insisted and led us every inch of the way. It just wouldn't have happened if she didn't pull us along. She also had to deal with child welfare, courts and everything and she never let up, with us or the [custody] case.
>
> Assistant Residence Director D:
>
> When she won the [custody] case she was flying high and you just couldn't stop her. I was one of the dubious ones: she was fine when you worked on her agenda but otherwise she was mostly uncooperative. And I worried about her keeping it together if she lived with her son. My feeling was she was the wrong person to spend all this energy on. But she had L. [the residence director] on her side. He really made a personal decision to help her. At the end, when she kind of backed off, most of us [staff] joined in giving her a final push but I still wasn't happy about it.

These three examples of "positively" discharged clients reveal a common pattern. Each initiated the discharge process and had to overcome staff ambivalence, skepticism and, in the case of F., some considerable staff hostility. The clients were self-motivated, initiated their own discharge plan and followed through with determination. While

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during this period. staff expressed a generalized hope that some clients would be able to move on to more independent housing. their instinct was to be protective and cautious and to preserve the community and their gratifying relationships with its client members.

Client Reactions to Positive Discharges: 1990-1994

The pattern of client reactions to positive discharges during this period was described consistently by staff. They attribute the clients' muted reactions to what they perceive to be client anxiety that is triggered when clients experience the discharge, even the positive discharge. of others. Staff expressed these ideas this way:

> Counselor J:
>
> You might think that when someone leaves Harlem House for something better that the clients would be very happy for them. But the [client] reaction has usually been pretty low key. I think the clients are happy to see the staff helping those who have decided they really want to move on, but they don't seem to be that excited for the client who's leaving.
>
> Counselor P:
>
> I wasn't surprised when the clients didn't react with much enthusiasm when D. and K. left. They were happy for D., that he was moving to the farm, because it was what he wanted. K's transfer to a scatter-site apartment was the other positive discharge that clients were pretty quiet about. I actually think that most of the clients were more relieved than happy for her because she could be such a difficult person. The clients always thought she was too self-involved.
>
> Counselor Q:
>
> I was expecting that the clients would really get into the party for F. She had worked awfully hard to get her son back and get an apartment. And the clients knew about it every step of the way. The afternoon of the party, though, only a handful of clients showed up. It was surprisingly quiet.

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The client attitude underlying these muted reactions was understood by staff as a reflection of the fear or conflicts that they believe most clients have about their own possible discharge from the program.

> <u>Senior Counselor F:</u>
>
> You have to understand that just about everyone at Harlem House talks about wanting to graduate and achieve things in their lives. Most clients talk a lot, but aren't serious about it. I think that when someone has really done it, it makes the other clients a little nervous. A lot of them are really scared at the idea of leaving Harlem House. So I think their happiness is mixed with some fear based on a lot of self-doubt.
>
> <u>Counselor K:</u>
>
> ...the idea of moving out of Harlem House is scary to a lot of clients. One day I was with N. and M. [two clients] and we were talking about F. getting her own apartment. Actually, N. did all the talking; M. didn't say anything. N. said she thought it was nice that F. was moving, but she said it without any enthusiasm.
>
> After dinner that night, M. [the other client] came up to me. She said, "J., don't want to move out. Will you make me move out?" I told her I was surprised to hear her talk that way. Where did she get the idea we would do that? She reminded me about the earlier conversation we had about F.

Staff Reactions to Positive Discharge: 1990-1994

Given the pattern of positive discharges during this period just described, the research found the staff's reactions following positive discharge to be consistent with their resistance and skepticism during the discharge process. In the interviews, staff expressed directly their reluctance to support the discharges, as well as a sense of foreboding about the future prospects of the discharged clients. Here again we see that, in this period, staff attributed higher social worth to those clients with whom they

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established gratifying relationships who were willing to stay at the residence "indefinitely" than to those whose self-motivation pressed staff to help them move on.

Concerns for Program Stability and "Client Replacement"

While concern for client welfare was cited most often by staff in their feelings regarding positive discharge, it is clear that there was also a more subtle concern about the stability of the residence and the "discharge replacement" process. Here we see a strong bias hinted at previously: during this period, staff sought to maximize stability in the residence by offering highly regarded clients a de facto indefinite stay. Discharging clients, especially positive discharges, posed a threat to stability since it was not known whether the "replacement" client would have a positive or negative impact on the residential community. Whereas the crisis of negative discharge demanded immediate action, thereby muting this concern about stability and "replacement," positive discharge posed the issue more directly: how do we know if the next client will be a positive member of our community? This bias toward maintaining the status quo is clearly evident in some of the staff comments regarding positive discharges in the early years and, as we shall see, dominated the staff reactions in the later period:

> Assistant Residence Director D:
>
> Sure I had mixed feelings about D. leaving. He could be so much fun and we all counted on him for a smile. I thought: who's going to come in next, someone like P.? [a particularly difficult and oppositional client who had a brief stay in the residence]
>
> Counselor Q:
>
> You could count on D. to pitch in, even when he wasn't scheduled for chores. He could drive us crazy with his little quirks but he was really sweet and as helpful as anybody... I didn't support the farm idea because I

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thought it was just too different from the way he was living. Plus I was worried about his meds. I thought he should stay here...Besides, you didn't know who was going to replace him. We get so many types and D. was special.

Counselor P:

All those months that K. worked on her goals I couldn't believe that she'd ever be able to make it in a scatter-site apartment. My feeling was she had everything she needed right here. We were used to her ways and knew how to handle her. [with a laugh] ...and she made chicken [for the evening community meal] that everybody loved.

Positive Discharges 1995-1996: The Impact of Environmental Pressure

In developing his theory of social worth and client outcome, Hasenfeld (1983) suggested that in addition to assigning social worth on the basis of client personal characteristics that other intervening variables play an important role. These "outside" influences include the "power differential" between clients and staff (i.e., the client's ability to capitalize on their social worth to obtain services); the cultural an normative context of organization and staff; and the political and economic needs of the organization and staff.

We suggested in Chapter 3 that there are significant difficulties in operationalizing some of these concepts and "weighing" them in any attempt to systematically track their impact on social worth and client outcomes. However, Hasenfeld's theory certainly appears to be confirmed when one considers positive discharges from Harlem House in 1995 and 1996.

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Background to Policy Change

In the summer of 1994, two significant policy initiatives in the agency's external environment combined to exert new pressure on residence staff to move clients more quickly through the program. First, Portals established its first "graduate" housing program, with funding from the State Office of Mental Health's (OMH) then newly established Supported Housing Program. Under this initiative, agencies could contract with OMH to establish permanent housing with limited support services for clients in the community. OMH contract funds were made available for rent subsidies (clients were expected to pay thirty percent of their disability income toward rent, with OMH paying the balance) and minimal case management services (one full-time case manager for every fifteen "graduate" clients).

With the establishment of its Supported Housing Program, OMH then significantly increased pressure on residential agencies to discharge clients from supervised programs (such as Harlem House) as quickly as possible so that its second companion goal could be achieved: the census rundown in the State psychiatric hospitals. OMH established Supported Housing in part so that clients who no longer needed 24-hour supervision could move to less supervised permanent housing, thereby allowing new clients from State psychiatric centers to fill vacancies in the supervised residences. This would permit the continuing run-down of the State inpatient census, a major cost-saving initiative.

Thus, in the summer of 1994, as Portals was working to establish the "graduate" program, it received a directive from OMH that included an expectation that the agency

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would admit 26 new patients directly from State psychiatric centers over the next year. This clearly meant that a like number of clients would have to move from 24-hour supervised residences to either intermediate housing (scatter-site supportive apartments with up to daily on-site staff visits) or to the new "graduate" housing.

Initial Staff Reaction to Graduate Housing: A Clash of Values

As predicted by the Hasenfeld theory, these environmental developments reverberated strongly at Harlem House. Over the two-year period 1995-96, nine Harlem House clients were discharged either to the scatter-site apartment program or to "graduate" housing. In reviewing these discharges, the research revealed that eight of the nine were initiated by staff; the client proposed the discharge in only one instance.

In the course of the interviews for this study, staff and clients described this period and their reactions to the process that was implemented. A new residence director, who had assumed the position in the spring of 1994, was given the responsibility by central Portals housing and management staff to introduce the concept of graduate housing to the Harlem House staff and clients. By the summer of 1994, two Harlem House clients were selected to join the Graduate Housing Orientation Group that was formed for the first selected potential clients drawn from throughout the Portals residential program. The two Harlem House clients were in the first cohort of graduate clients, moving from the residence in December of 1994.

Harlem House staff recalled their ambivalence about the developing graduate housing program. Initially they were concerned about whether the program would address the concrete barriers and issues that had always made independent living a

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dubious option (i.e, lack of sufficient income, affordable rent, loss of medical benefits, insufficient staff oversight and supervision). Clarifying these concrete issues, however, did not address some staff's concerns about the future wellbeing of the clients.

The research revealed that the program culture, which placed the highest value on caring for clients, not preparing them for transition, was directly challenged by the new graduate initiative. With this core value under attack, and facing the loss of the gratifying relationships with clients that they had nurtured, many staff were dubious about the graduate program, although they felt they had to comply with management's demands.

Staff recalled the introduction of the concept of "graduate housing" and their initial reactions. The paternalistic core values on which the program was based were clearly expressed:

> Senior Counselor E:
>
> I listened and heard all the good things [about graduate housing]: that the money would work out, that it would be permanent housing and that people would keep their Medicaid. I was concerned about the area where the apartments were going to be set up. I wasn't that familiar with it but I heard it wasn't good. I heard that the clients would have a Portals case manager but I worried that wouldn't be enough. I understood the idea and everything but it didn't feel right for everyone. I was worried that they wouldn't be able to handle it
>
> Counselor P:
>
> O.K., I got the point that their money would be O.K. and that they'd have nice apartments. But that wasn't really the point. We put so much time and effort into working with them just to see them go off somewhere and get into trouble. I thought there could be real trouble.
>
> Counselor J:
>
> I started working here the first day the residence opened and I can tell you that I hated the graduate housing idea. Maybe for some other

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clients who have it together a little more, but I didn't see it for ours, except for maybe one or two. B. [the residence director] asked us to suggest names for the program and I could go along in some way with J. and E. [the two clients selected for the original Orientation Group] But then we started talking about others and I couldn't believe it. I thought "no way"; they can't do it; this will be a disaster.

Given these concerns it is not surprising that staff continued to revisit these issues over the next several months:

Assistant Residence Director D:

We explained the details of the graduate program at a[n all-staff] meeting. I was really surprised by the staff response. They asked us questions about everything, money, case management, Medicaid, the rent, which we went over very carefully. They wanted to know about the neighborhoods where we were planning to put the graduate apartments and mostly how the clients would be supervised. I thought they were all good questions. I thought the staff was not too enthusiastic; I could tell they were concerned about the clients. It took a long time for them to accept it. In fact, they got more concerned as time passed.

Over the weeks and months it was kind of a trade-off. I knew that some staff were having a problem and I respected their issues. We went over the same details a lot. It's almost as if they wanted there to be problems or to create problems where there weren't any. Sometimes I had my own doubts, you know, but we pushed on.

Selecting "Graduates"

As mentioned above, there were a total of nine clients who "graduated" over the two-year period, 1995-96. Of these, only one client was self-selected (an original Orientation Group member). Thus, staff initiated eight of the discharges. The selection process, as described in retrospect to the researcher, elicited strong feelings in some staff in a number of instances. The research found that a central issue during the selection process for several staff was doubt about a particular client's ability to live successfully in the graduate program.

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In addition to the paternalistic concerns just discussed and staff's clear preference to maintain high social worth clients in residence indefinitely, as the "graduate" housing selection process unfolded, some staff described their becoming increasingly frustrated with their perceived lack of effectiveness in the selection process, although it remained largely unexpressed. As we saw in the exploration of negative discharges, there was a strong norm of staff participation in decision making.

Some staff believe that this norm was seriously violated in the selection of graduate candidates during 1995-96. They viewed the senior residence staff and Portals management as placing unreasonable demands on them to select a large number of clients, many of whom they either had serious doubts about or great attachment to. The negative impact on staff morale was clear in some of the interviews conducted during this period. The research found that as the selection process unfolded, an increasing number of staff questioned the choices being made, even though direct confrontation rarely occurred and staff went along with the imposed graduate transitions.

> <u>Senior Counselor F:</u>
>
> When we talked about J. and E. being referred to the first Orientation Group I thought "great, they were both very stable and doing their own thing and they would make it." Then B. and J. [the residence director and assistant residence director] asked for some more suggestions. We talked about some people and some I thought were a really bad idea. It's true that they were all currently okay, but I knew that some of them wouldn't be stable forever and that if we put them out on a limb and cut them off there would be trouble. I got frustrated and thought we were moving way too fast.
>
> <u>Counselor P:</u>
>
> I started to resent what was happening. It was fine with me if some of the clients moved to graduate housing. But I thought some of the choices

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were poor and they [senior staff] were responding to the pressure but not listening to us about some of our concerns.

Counselor J:

...To me, we were near the point of being disrespected as a staff. I thought of the old days and how this just never would have happened. ...I think we would have figured out some other way; appealed to L. [the director of housing] or you [the researcher and Deputy Director of Portals]. We would have done it together as a staff. Now nobody was willing to take it on.

Senior Counselor E:

Staff would come to me and say "there's no way so-and-so could ever be successful in graduate housing." And I felt kind of torn. I know that B. [the residence director] was under a lot of pressure to help fill the [graduate] beds and I knew we had to give our share. But I agreed that some of the choices were iffy. Even though we gave the clients goals they had to achieve [ability to self-medicate, budget their money, travel independently, etc.] and they had a lot of the responsibility, I agreed that some of the choices weren't good.

Some staff expressed their feelings in a number of meetings during the selection process. Ultimately, given the level of agency demand, the staff accepted the idea with the understanding that each client would have to prove himself or herself before the final discharge decision was made:

Assistant Residence Director D:

...at one [staff meeting] we were talking about S. and some staff expressed a lot of concern and doubt. J. [a counselor] expressed concern about the idea that we would even consider S. for graduate housing, with her history. I could tell that some others felt the same. "All right,' I said, "let's just wait and see if she can pull it together." J. [the counselor] said he thought it was a waste of effort because even if she was able to achieve some of the milestones we still knew her well enough to know that it wouldn't last. I said "let's wait and see."

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Community Reaction to the Discharges

Client Reaction

According to staff, during the early part of this two-year period, clients displayed the same reaction pattern that they had to the positive discharges that occurred from 1990-94. Staff recalled clients expressing the same kinds of ambivalent reactions as in the earlier period. As the pace of selection for graduate housing accelerated in 1995 and throughout 1996, staff reported that clients began to react differently to what was occurring. Most staff described a similar client reaction pattern, constituting a two-phase phenomenon.

First, many clients more directly posed the question: "Why Not Me?" This seemed to represent their perception that not being chosen at this time reflected negatively on them. Beyond the question of whether they actually felt prepared to move on or even whether they were genuinely interested in doing so, staff reported that clients were competitively vying to be selected by staff as an important gesture reflecting their standing in the community, their accomplishments and their sense of self-worth. Several clients who were not selected angrily demanded to know why and, despite staff efforts to process the issue with them, were reported to feel rejected or angry.

The second phase of the client reaction occurred as the pace of actual discharges quickened. Staff reported that several clients who were not discharged became disoriented with the constant discharge and admission of new clients and that the loss of so many important clients from the residence destabilized some of those left behind.

This typical client reaction pattern was described by several staff:

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Counselor G:

At first, the clients seemed to accept the discharges. When J. and E. graduated there was a big party and spirits were pretty good. It felt pretty normal. ...when staff began to talk to other clients about moving, things started to change. Staff talked to so many people and the clients started reacting. I think the ones who weren't asked got jealous. ... I couldn't believe that M. [a client with multiple needs who is clearly not a candidate for graduate housing] came to me. She was angry about not being picked. There were others too.

Counselor J:

The worst was in the fall of '96 when the big group was getting ready to move. The other clients just freaked out...I never saw so many depressed people at the community meeting. You could hear a pin drop the whole time. There was so much tension that M. and P. [two clients who normally had a positive relationship] had a big fight over the menus for the week.

Counselor L:

You could tell that some of the clients were getting upset. Those who weren't moving didn't know whether to feel good or bad. They saw all the attention the graduates were getting and wanted it too. It was too confusing for them. I thought that R.'s hospitalization [which was during this time] was partly because she couldn't handle the stress of all the changes.

Senior Counselor E:

I saw so many of the clients get upset as time went on. S. [one of the articulate clients who often expressed feelings on behalf of the group and who herself moved to graduate housing at the end of the two-year period] came to see me and kept muttering that what was happening was wrong, that too many were leaving. She said it reminded her of the "dark days" when she was homeless without any family. "You have to stop," she said, "it's wrong."

Staff Reaction

Reactions among staff were equally as strong. While on one level staff was receiving positive reinforcement from senior residential and agency management and

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viewed some discharges very positively, they had serious reservations as events unfolded. Long-term staff in particular looked back with very negative feelings to the cumulative effect of the enormous client turnover over the two-year period. The clash of values that was expressed by staff as their initial reaction led in some cases to significant bitterness as staff described the losses and transformations that the program experienced. Indeed, the majority of long-time staff interviewed viewed the period with regret and anger. To them, these were not positive discharges at all, but marked the disintegration of highly valued relationships and a growing instability of the residential community.

In Hasenfeld's (1983) terms, the criteria of social worth, the attributions of social worth and the relationship between social worth attribution and client outcomes became highly problematic and conflictual issues. On the one hand, messages from senior agency management imposed a new standard of high social worth: the client's ability to make the transition to graduate housing. On the other hand, the fact that this attribution was imposed and did not arise naturally from within the community posed serious conflicts for staff, many of whom viewed themselves as participating increasingly in the demise of the community that they had worked so hard to build and nurture. Shock, bitterness toward senior management and a sense of mourning (toward those discharged and toward the program culture itself) were expressed by many staff who reflected on the severing of relationships and what they identified as the growing instability of their common endeavor.

Counselor P:

> It kind of started out like a good dream and then became a nightmare. There were clients we knew could make it and we were sorry to

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see them go but we felt good about it. When it got out of hand, though...we [the staff] got angry. How could they [senior housing and agency management] even think that they could strip us this way. When the big group left [in December of 1996] I couldn't believe it. It tore our heart out...we're professionals, but the point is you don't do this to professionals, you recognize how devastated we would be.

Counselor I:

We were between a rock and a hard place. We were expected to move everybody out and feel good about it, but some staff was just miserable. On some days I felt a lot of positive energy, the clients were into it and I thought it would be okay for them. But we lost too much...I felt dizzy.

Counselor J:

Everything we counted on was gone. The clients we cared about, the people we counted on to be there to do things and to share with. You won't believe this but I had to actually sit down and write out the rules and post them in the community room because there was no one left [no clients] to explain them to all the new people coming in. Can you imagine after six years having to start over like that?

...I thought about all the work we had done and I couldn't believe it was happening. When the big group moved out it was like death. The party was a joke. Nobody was happy. For days after it was so quiet, everyone was freaked. We were busy trying to cope with the new admissions, but we were also mourning because our golden time was over.

Compounding the sense of loss were the reactions of staff to the parallel process of inducting new clients ("replacements') into the program. Since turnover was so large and vacancies were discouraged because of their negative financial impact (the agency's housing contract includes client-generated SSI funds in its funding formula), staff were under considerable pressure to fill vacancies quickly. Staff expressed concern about this process which it viewed as too indiscriminate. Clients were selected without the

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conscious efforts of the earlier period to "balance" the group (by gender, race, functional abilities and the like). According to staff, this balance had always been essential to the smooth functioning and positive atmosphere at the residence.

> Assistant Residence Director D:
>
> Don't forget we also had to fill all those empty beds... In the old days we were more careful about how we did this. If someone left who was a strong leader, we tried to recruit a new one. But now we were faced with all these vacancies and we pretty much filled them with whoever was in the pool. It was a different kind of group, a lot quieter, lower functioning... I couldn't see how we could get back on our feet with them.
>
> Counselor P:
>
> ...this really bothered me. We lost so many who did a lot around here. We replaced them with people we didn't know. They came in a flood and it felt overwhelming. They didn't know anything about our ways or what we expected. At the community meeting, I would think about S., J. and M. [three "graduates'] and how they would participate and help us. I missed them and all there was silence.

Clearly, in the aftermath of the positive discharges in 1995-96, the staff perceived that the program was experiencing a major trauma. With valued relationships severed and a new group of unknown and unknowing "replacements" staff expressed a combination of loss, anger and anxiety about the future.

Chapter Summary

In this chapter we have examined the phenomenon of positive discharges during the first six years of the program's operations, its relationship to evolving agency policy and the ways in which social worth concerns played out over the period. Figures 3 and 4 illustrate the major concept and their relationships over the six-year period.

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Figure 3. Positive Discharge 1990-1994

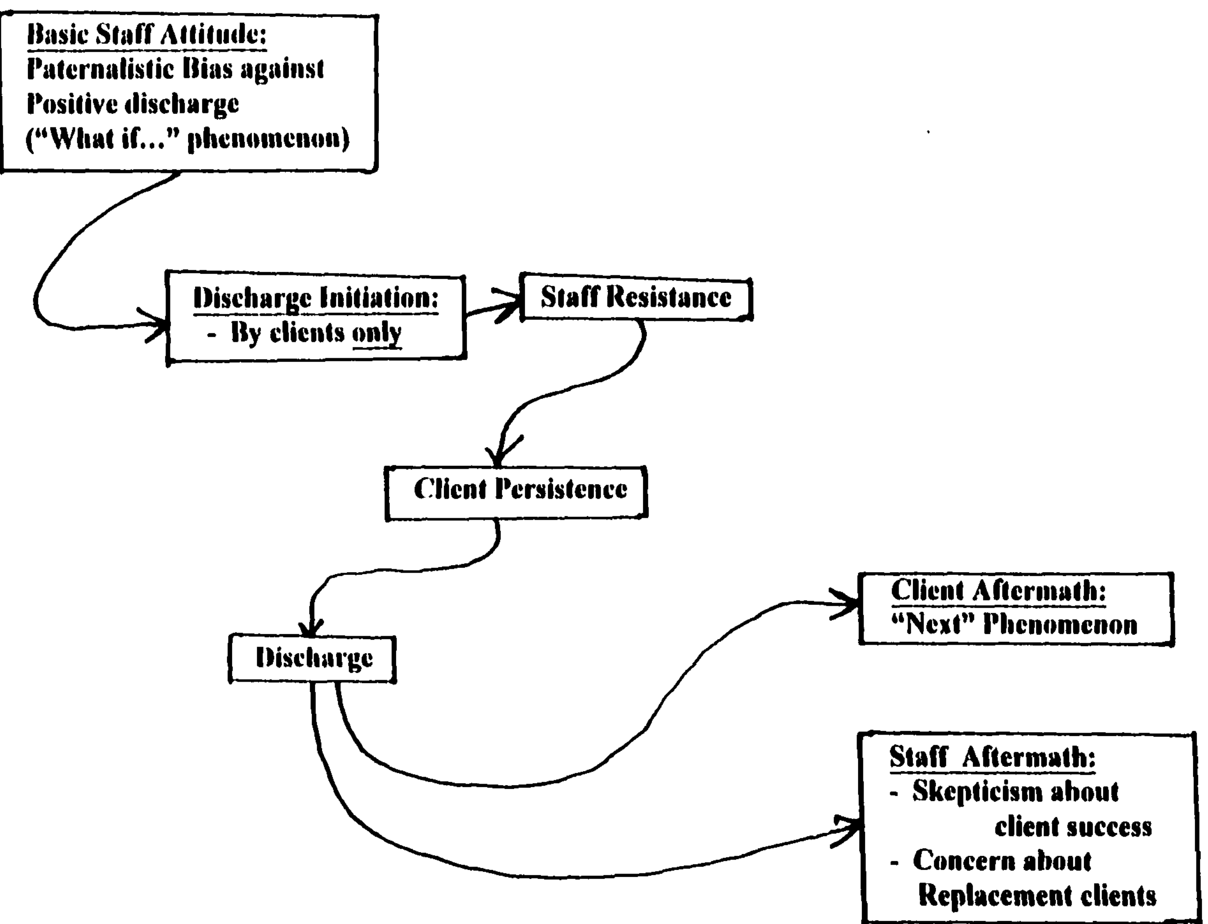

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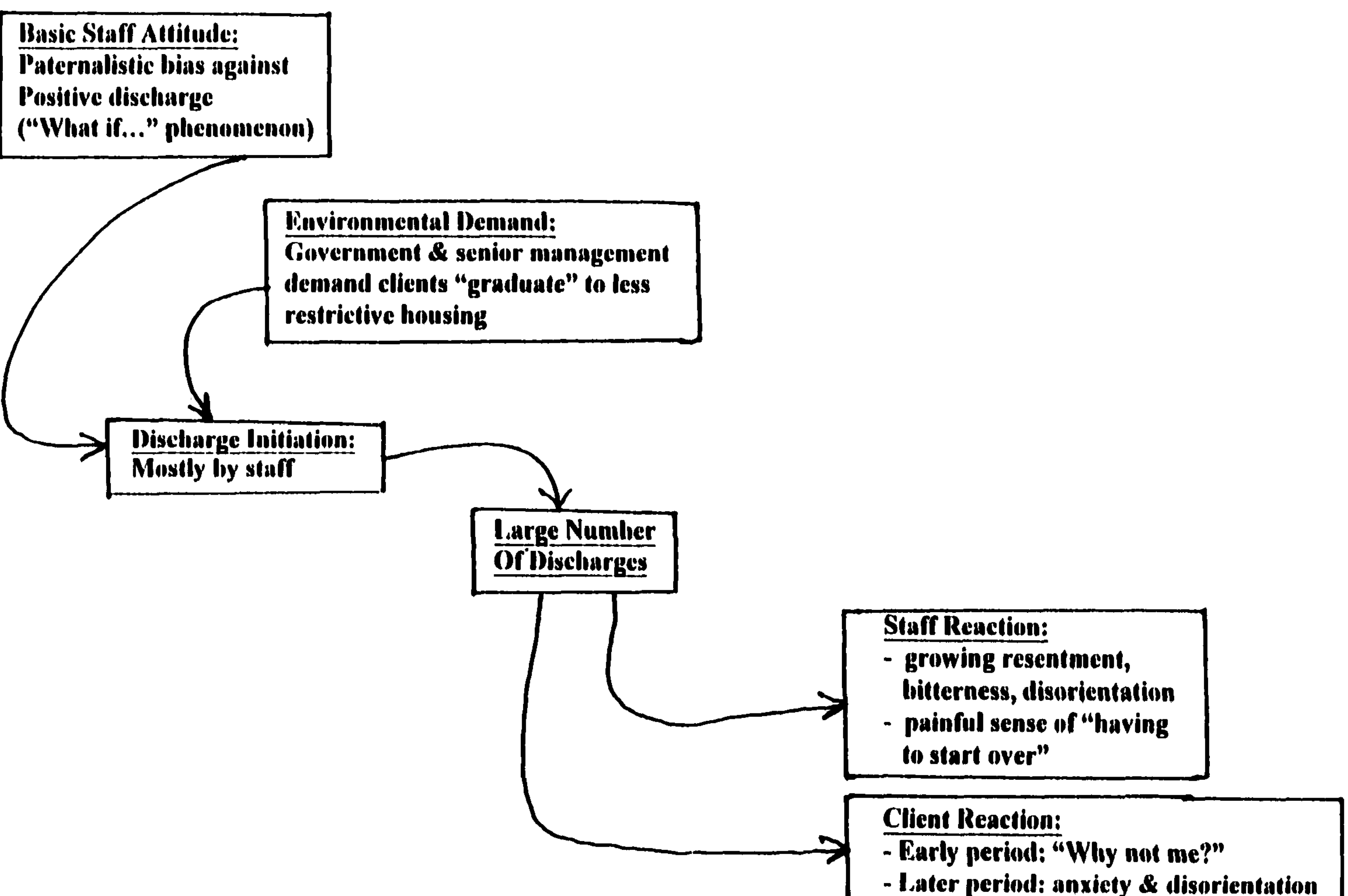
Figure 4. Positive Discharge 1995-1996



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In the early years, we found that clients interested in positive discharge had to overcome substantial staff resistance. During this time, staff clearly preferred to have high social worth clients remain in the residence indefinitely to maintain their mutually-gratifying relationships. Overcoming staff resistance was no simple matter. Clients had to be extremely persistent and had to overcome a number of hurdles that staff imposed in order to "allow" them to move on.

Client and staff reaction to these early positive discharges followed a clearly delineated pattern. Clients most often displayed a muted reaction which staff interpreted as reflecting underlying conflicts around the prospect of having to leave the residence at some point. While many clients often spoke of their desire to move on, beneath the level of this rhetoric staff believed that clients had a significant fear of losing the care and protection of the program.

Positive discharges in the early years elicited mixed reactions from the staff as well. While they acknowledged that the clients had achieved all that they needed to in order to "qualify" to move on, staff remained skeptical about the abilities of those discharged to maintain themselves in more independent housing. Clearly, staff preferred to have clients remain and viewed positive discharge in part as destabilizing to the program because of the unknown element: who the "replacement" would be and the impact he or she would have at the residence.

In 1995-96, external and agency environmental forces resulted in a major initiative to drastically increase the number of "positive" discharges from the residence. As predicted by the Hasenfeld (1983) theory, staff reacted to these pressures strongly.

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Initially, they were wary, expressing concerns about the welfare of discharged clients and resisting the loss of relationships and program instability that a large number of discharges would entail. In retrospect, several staff reported that the process of selecting potential positive dischargees created resentment. They believed that too many clients whose presence in the residence was too important were being targeted. While staff went along with senior management, many had growing private doubts and frustrations.

Client and staff reactions to the large number of discharges were similar. Many clients initially challenged staff angrily if they were not selected ("why not me?"). In the course of the two year period, however, staff reported growing client anxiety and disorientation as losses mounted and so many new faces appeared. At the same time, staff experienced increasing shock and bitterness and a pervasive sense of mourning. The parallel processes of discharging valued clients and admitting "unknown" replacements led some to feelings of resentment and despair.

The presence of the phenomenon of social worth is clearly evident in the history of positive discharges at Harlem House. The primacy of this phenomenon is reflected in the staff's actions and reactions over the six-year period. As we have seen, gratifying relationships are highly valued and only very reluctantly severed. While the external and agency pressures of the later period were strong enough to demand staff compliance in the positive discharge initiative, we have seen their negative impact on both clients and staff morale. It is not surprising, then, that this period was followed by a substantial number of staff resignations and reassignments. By the middle of 1998, only two of the original ten staff members remained at the residence.

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CHAPTER 8

Social Worth In Action: The Case of Continued Stays

Introduction

Beyond negative or positive discharge, the third alternative outcome for clients who are admitted to social programs is continued stay. This chapter will explore the continued stay phenomenon at Harlem House over the six-year study period. It will review the phenomenon from both staff and client perspectives. For purposes of the study, continued stay was defined as a minimum thirty month stay, reflecting the regulatory agency's policy that stays are to be limited to an average of twenty-four months for this transitional program. When applying the thirty month standard, the research found that eleven clients were designated as continued-stay.

Using Hasenfeld's (1983) concept of social worth as a frame of reference, the researcher explored with staff and clients several key questions about continued stay: 1) Who does staff "select" for this special status?; 2) What are the characteristics of those selected?; 3) What roles do such clients assume in the residence?; and 3) how do staff and clients view this kind of client longevity in the program? In answering these questions, the research clearly revealed the dynamics of the social worth process at Harlem House.

In view of the important findings already presented in the chapters on negative and positive discharges, which highlighted the value of mutually gratifying relationships between clients and staff, it is not surprising that the research found the notion of

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relationship at the core of continued stay dynamics. A clearly identifiable pattern of relationships between continued stay clients and staff was found.

In our discussion of negative discharges in Chapter 6, we touched on basic staff attitudes towards and expectations of clients at Harlem House. It was pointed out that staff are usually willing to work with clients with the proviso that they exhibit an essential basic behavior: cooperation. As we have seen, oppositional and non-cooperative clients are assigned low social worth rankings by staff and are at high risk of negative discharge.

In exploring the phenomenon of continued stays, staff affirmed that a cooperative client attitude is the necessary condition for establishing gratifying and lasting client-staff relationships. Staff also elaborated on the client qualities that they valued most and the kinds of relationships that secured continued stay status for some. Again, the research found that an individual client's ability to achieve the major manifest goal of the program, the transition to less supervised housing, was not the highest value to staff. However, staff did express a strong desire to see clients "make progress" in their rehabilitation. As we shall see, this kind of progress contributes significantly to staff job satisfaction.

Thus, the kinds of clients that staff valued most, and were most often "selected" for continued stay, were cooperative, expressed gratitude for staff efforts, and had progressed in their rehabilitation efforts. In addition, staff acknowledged that some continued stay clients played some special roles in the group life of the program. These "community-building or enhancing" roles were especially valued by staff. Significantly,

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clients who exhibited very poor functioning (and who in staff's opinion were thereby disqualified for less supervised housing), were not automatically excluded from selection for continued stay status. Again, with a basic cooperative attitude, such clients could be selected to remain in the program indefinitely.

The specific kinds of client-staff relationships that staff value most are best understood in the context of basic staff attitudes towards the clients in general. In our discussion of negative and positive discharges we saw that staff view Harlem House as a unique refuge and life-sustaining resource. The primary staff attitude toward negative discharge, that it consigned clients to resumed homelessness and the havoc of untreated mental illness, and even the staff's concerns about the fate of those positively discharged, underscore the staff's fundamental belief that they are responsible for near-life-and-death decisions about clients.

In terms of continued stays, staff express the same kind of ideas, but from a positive rather than negative perspective. Homelessness, life on the streets or in the shelters, loss of contact with family and friends, untreated mental illness are all seen by staff as conditions that signify that the clients have "hit bottom" prior to their admission to Harlem House. Staff view Harlem House above all as an opportunity for client to begin a new life. In staff's view, their essential role is to provide nurturing and teaching, just as they view the essential client roles as cooperative participation in their "community." In describing these shared values staff often use analogies and metaphors that refer to Harlem House as a "family." Staff view themselves as nurturing and instructive "parents" and view the clients, metaphorically, as "children."

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In the interviews, most staff expressed this clearly defined vision of their work, mindful of their parental role in helping to restore the clients' lives:

> Counselor K:
>
> I figured out pretty quickly that even though some of the clients were twice my age that we [staff] are the parents and they [clients] are the children. I didn't think that parenthood would be part of the job, but I learned...They're so fragile, you have to bring them along with a lot of caring and support...Then, you can work with them on learning what they need to know to make progress.
>
> Senior Counselor F:
>
> You can't get much lower than our clients...they've lost everything. We're saving their lives every day...but that's just really the beginning. They go through a rediscovery here, rediscovering themselves. We care for them and we guide them. That's our role.
>
> Counselor Q:
>
> [The clients] are like young boys and girls, like our children... They need to be coddled and they also need to learn. We do both.

With this universally articulated staff view, it is clear why such a great value is placed on client cooperation. When clients participate cooperatively in the nurturing and teaching opportunities that staff offer, staff feel gratified. When combined with real "progress," some visible or acknowledged sign that a client has actually acquired a new skill or ability, staff report both gratification in their relationship with the client and overall high job satisfaction.

The "progress" that staff is looking for is often described by them as a client's new ability to perform basic self-care tasks more independently or, as a client's newly enhanced relationship skills at the residence (being more related or cooperative or

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assuming leadership in some way). Staff feel great personal and professional satisfaction when this occurs:

> Senior Counselor D:
>
> When I see someone like C. [a client] making progress like that I do really feel professional satisfaction. When I remember how she came in here a poor little thing who wouldn't even talk to you but she gave you those soulful looks...It took three years, but she's really a new person. When I see her listening and following through on what we're asking her to do, it's just fantastic. She is trying so hard and we are helping.
>
> Counselor J:
>
> It doesn't get any better then when you can actually see the clients making efforts and succeeding. I'll never forget the first time M. [a client] did her hair. Her hygiene was so poor for so long and she came into the community room one day after with it [her hair] all done up. It's like you remember where you were when Kennedy was shot. That's the way I felt about M. that day, that I would never forget it, that she was so proud and I was too.
>
> Counselor P:
>
> You could never say that you work at Harlem House to get rich. But you get so much more when you see a client make real progress. When you see one of your brand new toddlers, who couldn't even walk or run taking charge of their lives, it's incredible. You feel so good that all the problems and heartache just disappear. Then I think this has to be one of the best jobs you could have.

"Community Builders and Enhancers:" High Social Worth Roles in Continued Stay

In exploring the phenomenon of continued stay another underpinning of gratifying relationships emerged: a pattern of specific client roles that staff view as essential to building and maintaining a positive community. Clients and staff form important partnerships to assure the smooth operation of the residence and to contribute

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to the positive tone of the community. In exchange, such clients are designated with high social worth by staff.

Beyond simple client cooperation, the research revealed a number of sub-categories of clients who play specific roles as "community builders" or "community enhancers" in the residence and who thereby earn high social worth status. Such clients are routinely selected for continued stay status. Most of the defined roles revolve around specific clients assuming some leadership function in helping to build or enhance a smooth functioning, positive residential "community." In this subcategory are the **helpers, teachers and enforcers.** As described below, these roles pertain to gaining and maintaining a cooperative client community. **Cognitive leaders** are clients who the staff rely on to analyze issues and formulate ideas. **Affective leaders** are clients who express emotions readily, in a way that staff believes is positive and useful for the community. A special sub-category, **the diva,** is a unique helping role that combines several of the above traits in a single individual client, who thereby gains significant rights as well as responsibilities.

The research found that not all high social worth continued-stay client roles are confined to the area of gaining or maintaining community cooperation or contributing to the smooth operation of the residence. Some clients, **the deserving needy,** are selected because there is staff consensus that they require the intensive level of services at Harlem House indefinitely. These clients are not expected to be able to progress to less supervised housing and to their continuing functional deficits. Through their cooperative

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attitude and some discernible progress, however, they have gained the staff's commitment to work with them for an unlimited period of time.

Finally, the research found a sub-category of continued stay clients, primarily in the **deserving needy** sub-category, who have had strong external advocacy from families that closely monitored the client's life in the residence. While in some cases staff views such involvement negatively and as intrusive interference that confers low social worth on the client, the research found that some families are viewed as a positive and sustaining presence which staff welcome. Such families help cement the staff's commitment to designated selected **deserving needy** clients for continued stay.

Helpers, Teachers and Enforcers

According to staff, client participation in "carrying" and/or maintaining the culture of the program exists across a continuum of client roles. While multiple roles can be filled by a single client, staff identified three basic functions which in some instances may be assumed by different clients.

At the most basic level are the **helpers.** These are clients who assist staff in carrying out basic functions in the day-to-day operation of the residence. This role is limited to giving concrete assistance. While such clients cooperate with staff and are willing to "go the extra distance" or "pitch in" beyond the baseline of what is required, they do not play an active "teaching" role. Such clients will step in to be involved in meal preparation (shopping, cooking, clean-up) when those who were originally scheduled cannot. They will also readily agree to go on errands for staff (such as bringing documents to Portals, picking up documents from a nearby hospital or program,

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shopping, etc.). And they often assist with special events, such as birthday or holiday parties (i.e., helping with planning, decorations, special cooking).

Helpers are highly valued by staff because they provide back-up in the event a client scheduled for specific chores cannot perform them and because they contribute to the smooth operation of the residence through their voluntary efforts. Thus, while this is a limited role, it is nonetheless viewed by staff as an important one:

> Senior Counselor E:
>
> M. was certainly not the most verbal client and she was very quiet most of the time. But we knew she would volunteer to pitch in when someone couldn't do their meal chores. It gave staff some security knowing that M. was there if we needed her.
>
> Counselor L:
>
> Every time we had a birthday party or when we were planning Thanksgiving or Christmas, J. [a client] would be there to help. She wasn't really a "party girl," very often she wouldn't say much or participate much during the event. But everyone [staff and clients] appreciated how hard she worked and she got a big round of applause.
>
> Counselor I:
>
> We [the staff] used to joke that we couldn't run the place without D. He was always doing something for us: shopping or taking stuff to Portals. After so many years of doing this, we sent him to S. [the Portals vocational director] so that at least he would get paid as a messenger for the trips back and forth to Portals.

Next in the continuum of high social worth roles that gain or maintain client cooperation are the **teachers.** These clients are not just cooperative or helpful; they assume an active role in inducting clients into the program culture. According to staff, the teaching role usually begins prior to the time of admission, when potential new residents attend a community dinner. This ritual not only gives both staff and clients an

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opportunity to evaluate potential new residents, it is also used to "test out" the potential client's reactions to the expectations that the program imposes. **Teachers** often play an active role in this process during pre-admission dinners, seeking out the potential new client and providing general information and an orientation. A counselor described this teaching function:

> Counselor P:
>
> It kind of became like a ritual. Whenever a potential client came to dinner N. and S. [two clients] would go through their paces, describing all the rules and expectations at the residence. It's like they rehearsed it; they divided up the topics and each would go over the details. Staff only got involved when there was a question that N. or S. couldn't answer.

Once admitted to the program, **teachers** often reach out to new clients to "show them the ropes:"

> Assistant Residence Director D:
>
> F. [a client] always took new people under her wing. She would fuss over them and ingratiate herself to them, but she was also tough. She laid down the law and made her expectations clear. And just like a mother bird she would send them from the nest to make way for her next babies.

Staff relies heavily on **teachers** to perform these functions and, as described in Chapter 8, felt a great loss during the time when a large number of them moved to graduate housing, leaving the program without this essential client role.

As described by staff, the role of **client-enforcer** has been essential at the residence. **Client-enforcers** are both a first line of defense against community rule-breaking and an important tertiary defense system. As we saw in Chapter 7, clients rarely publicly call for the discharge of fellow clients. However, **client-enforcers** are active both in community meetings and private interactions in maintaining adherence to basic

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operational rules. **Enforcers** typically monitor compliance with mealtime chores and other community basics such as cleanliness and maintenance of the community kitchen, dining room and lounges, use of the laundry facilities, smoking rules and the like.

Staff value the clients who play this role as primary, first-line defenders of the community's norms and rules. Staff encourage this role since it allows them to be less confrontational with casual rule-breaking, reserving the rather limited range of staff sanctions for more serious incidents:

> Residence Director A:
>
> We always prefer to have clients correcting other clients if they stray on the more minor quality of life rules. It's both therapeutic for the clients who monitor and helps keep everyone on the straight and narrow, modeling some very positive behavior, and it keeps the staff in reserve to deal with the serious problems.

. In discussing this role with staff, several pointed out that although they were initially concerned about enforcers becoming overly punitive, that this had rarely happened. Staff discussed some isolated instances in which their intervention was needed to regulate **enforcers**:

> Counselor J:
>
> There were a few times when we [staff] felt that a client was too harsh with someone, but we were able to handle it. It's been a real benefit, though and very beautiful to have the clients so involved in keeping things running right.
>
> Counselor G:
>
> Sometimes I felt that R. [a client] came down too hard when someone did something wrong. D. [the assistant residence director] and L. [the residence director] spoke with her about it and that seemed to help. We

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always watch to make sure that the clients are appropriate with each other.

The tertiary role that **client-enforcers** play occurs after an instance of major rule-breaking which threatens a client's continued stay at the residence. As discussed in Chapter 6, community meetings following such incidents are often very quiet with staff explaining what has occurred and what the fate of the client will be. While clients do not generally say much in these meetings, there are usually one or two clients who will speak up in support of the staff. More importantly, as described by staff, **client-enforcers** play a role in the weeks after a negative discharge, reminding the community why such a severe action was taken. Staff considers this function to be very important:

> Senior Counselor F:
>
> When there's a big incident and someone has to go the clients are usually in a state of shock. It's the next few weeks where people come to terms with it. Some of the clients really help with this, going over the details. I've seen the clients explain it better than the staff and the other clients listen.

Cognitive and Affective Leaders

Another essential "community maintenance" function revolves around a subcategory of clients whom staff identify as **cognitive** or **affective leaders.** Staff readily identify clients who play the essential roles in formulating "ideas" for the community and others who express emotions. Both of these roles are highly valued by staff since many clients have limited cognitive and affective abilities stemming from their psychiatric condition. **Cognitive** and **affective leaders** are accorded high social worth status by staff.

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Cognitive leaders play an important role in solving the community's problems. from the more mundane to the vitally important. such as developing a new procedure for selecting which programs to watch on the community television or revising the method of distributing personal allowance funds or medication. In the daily life of the residence such matters. trivial and serious. continually need to be addressed. In this process. staff look to the **cognitive leaders** to help formulate solutions. Many staff highlighted the importance of this kind of client input. both as a positive way in which clients can participate in community life and also seeing its advantages in promoting cooperation and compliance:

> Counselor K:
>
> We [staff] realized pretty early that we could rush in and solve all the problems if we wanted to, but L.[the Residence Director] talked to us about having the clients participate in the process. I've seen so many examples where this is the right approach. First of all, when the clients come up with the ideas you feel good that they're taking charge and growing... I've also found that very often it's a lot easier to get their cooperation when they're part of the process.
>
> Counselor I:
>
> J. [a client] was one of our really good thinkers. At the beginning of her stay she would tentatively make suggestions. After about six months, staff and clients would automatically turn to her when a problem had to be solved. She grew in the role, which staff and clients counted on. We [staff] knew that if J. came up with the idea it would help the other clients accept it.

Equally as important to staff are the **affective leaders**, those clients who can be counted on to express emotions and feelings for the community. Again. because of their psychiatric condition. many clients have a limited ability to express a full range of emotions. Staff often consciously model such behavior for clients. as when they express

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sadness or other emotions at community meetings when a client is discharged. They also identified a number of clients who serve this important function.

As discussed in Chapter 6, S. was a client who readily expressed emotions for the client community, often expressing sadness, dismay and regret in the aftermath of negative discharges. According to staff, S. could also be counted on to express "positive" emotions such as congratulatory expressions during birthday parties or holiday events. When a client achieved an important milestone – "graduating" to a higher level of MICA treatment or getting a job either inside or outside Portals – S. would passionately lead the expressions of congratulations. Staff appreciates this role, both for the positive modeling it provided to other clients and to buoy the mood in the residence:

> Senior Counselor F:
>
> S. could get carried away at times, a little histrionic, but really it was wonderful to have her making a fuss over a client and expressing the feelings for the group. She could be very endearing and the clients and staff always looked forward to her little speeches filed with so much caring.
>
> Counselor M:
>
> When S. was around we knew that the feelings would flow more. She would always start and one or two others would pick it up. If no one else did, at least S. got the feelings out there.

In discussing the affective needs of the community, most staff mentioned the special importance of clients who possess an outgoing sense of humor. This special kind of **affective leader** is very much appreciated by staff, who often cited this quality as being among the most important in attributing high social worth and in establishing gratifying staff-client relationships. Clearly, in a program in which many of the clients

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have the kind of constricted affects often associated with schizophrenia. those who can inspire laughter or react with a spontaneous sense of humor are highly valued.

Outgoing clients who posses a good sense of humor are referred to by some staff as **"entertainers"** and staff talk about them with warmth and appreciation:

> Counselor N:
>
> I can't tell you how much a difference it makes to have to have someone like F. in the residence. You think of him and you just smile to yourself and remember the last funny thing he said. He's only one, but he can fill the whole place with his jokes and laughter.
>
> Assistant Residence Director D:
>
> R. was the life of the building; he was so funny. I swear he would stand up just like an entertainer and do jokes. We spent so many evenings laughing; the staff and the clients loved him.
>
> Counselor M:
>
> M. made us laugh a lot. When I had to switch shifts to the evening and I was so upset I remember thinking, "well, at least I'll spend more time laughing with M."

Thus, we see the power of client humor, not only in binding staff and clients, but also in providing staff with a highly prized enhancement in their work lives.

The Divas

In reviewing the characteristics and sub-categories of continued stay clients with staff. most described and returned often to a rarefied role that they call **the diva.** As the name implies, all of these are female clients (several staff pointed out that Harlem House is a community with "many client-mothers." but no "client-fathers"). At any given time. there is a relatively small number of **divas.** usually no more than three. **Divas** play a

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fully-realized role that is both self-acknowledged and acknowledged by staff and clients. They are multi-dimensional mother figures who nurture (or "pamper"), teach and enforce. As such, they are leading figures at the residence. Because of their ability to influence others in establishing basic cooperation and routines, **divas** are accorded considerable staff respect. With such respect, **divas** are granted "privileges" that further enhance their stature in the community.

While the privileges accorded to **divas** are usually more symbolic than material., they are clearly recognized by staff and clients. Their opinions are sought out by staff and given special consideration. Staff report a tolerant attitude toward them. Even when staff disagree with them, if a matter is not critical, staff are often willing to give **divas** free reign in problem-solving or defining client expectations. Several staff referred to this phenomenon as an "accommodation" to show respect and appreciation to the clients who assume this role.

Staff consciously monitor both the way in which **divas** relate to other clients (making sure that they do not abuse their authority) and the competition among them. While the basic nurturing and maternal instincts of the **divas** usually produce positive and "pro-community" behaviors, staff report that on occasion they have intervened to curb a **diva's** behavior when staff feel it is playing out negatively for an individual client or the community as a whole. Such intervention usually occurs in private meetings with senior staff and a **diva**:

> Senior Counselor F:
>
> Our **divas** have clout. Most of the time, they play a very positive role, "feeding their young" and tending to them. Staff respect them and

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count on them. The trade-off is that some of them feel entitled; they feel they can say anything [emphasis hers] at any time. Sometimes one of them will go overboard and take advantage by asking one of theirs to do too much. This happened with S. a few times and we (staff) had to intervene.

Assistant Residence Director D:

L. (the residence director), A. (the senior counselor) and myself talked about how to deal with S., who was making too many demands on N. [a male client who was very attached to S. as a maternal figure]. L. [the residence director] thought it was not a good idea to talk about it in the community meeting, since the questioning of S.'s behavior might upset a lot of the clients. So we talked with her privately and I must say you could tell after that she backed off with N.

Counselor P:

At the staff meeting [several counselors] expressed concern that C. [a **diva**] was acting harshly towards H. [a male client who was very attached to her]. Staff observed that C. was having H. go to the store for her a couple of times a day and was dictating to him about his kitchen chores. Staff thought the tone was too punitive and that C. should be talked to. L., D. and A. [the residence director, assistant residence director and senior counselor] tag-teamed over a few weeks to address C's behavior. Eventually she got the idea that staff was serious about backing off with H. and she went along.

When competition among **divas** occurs this becomes a serious staff concern. As described by staff, not all **divas** are competitive; a few are content to take charge of those clients who seem to be attracted to them naturally. However, when there is significant open competition among some **divas,** staff moves quickly and definitively to address it. In reviewing these kind of situations, the research revealed that staff consistently intervened in such a way that would not directly challenge the **diva's** status or general role, which staff value, but rather focussed on the specific situation at hand, thereby actually enhancing the **diva's** sense of power and effectiveness:

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Residence Director A:

You can't have a situation where clients are being pulled in two or three directions at the same time. This puts the clients in a bad position and is also a kind of direct message that staff have given up their authority. While we've had a pecking order where there's a certain amount of deference paid to the more senior [**divas**] and the turf gets divided up pretty easily, there have been times when there's been a lot of conflict. You really want to nip this in the bud. We'll confront the parties directly and make it clear that this is not acceptable.

Senior Counselor E:

I thought that S. and C. [two **divas**] were going to kill each other, that's how bad it got. They were arguing at every community meeting about everything and it was confusing everybody [the clients]. L. [the residence director] and I met with S. We didn't directly challenge her authority really, we just talked about how she and C. seemed to be disagreeing more lately and that it was upsetting everyone. S. kind of took this in her regal stride, I think she felt flattered that we talked with her this way, bringing her a serious problem.

Assistant Residence Director D:

The trick with the **divas** is not to go too far. We [staff] accommodate them because they are so important around here. So if you have to call them on something you want to be firm, but you don't want to completely pull the rug out from under them. The way that has often worked best is to flatter them a little but also be clear about the problem and our expectations.

The physical illnesses, psychiatric hospitalizations or discharges of **divas** from the residence create great concern among clients and staff. In 1995, two **divas** were discharged to a Portals "graduate" housing program. As discussed in Chapter 8, staff reported their own upset and heightened client upset when these losses occurred, initiating a time of mourning and anxiety as the community paused to wait for the next **diva** to emerge:

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Senior Counselor F:

> After S. and C. left we were disoriented for a long time. I wanted to reach out and say to someone, okay you've got to rise to the occasion now, we need you. But I couldn't, we just had to wait. We [the staff] saw how much they [the clients] missed them and we were sad too. It was the hardest time.

Counselor J:

> First S. left and then C. a few months later. Everyone felt it, like our heart was cut out. The clients were so quiet and you [staff] didn't know what to do, we were so used to them taking charge. It was hard and confusing for everyone and I learned looking back that you just had to go through it. It took months for J. [a client] to come out of her shell and assume some leadership. Until it happened, it was depressing for all of us.

Given this level of client and staff attachment to **divas**, it is clear how important their role became in the residence. The high social worth accorded them by staff and the staff's strong reactions to their incapacity or departure reflect the **divas'** high social worth status as continued stay clients. In the early years of the program, the prospect of discharging a **diva** was resisted strenuously by staff. As discussed in Chapter 8, the culture of residential "transition" developed among clients and staff only with significant external pressure from the Director of Housing and senior Portals management. When moving to "graduate" housing began to confer enhanced social status on those clients who were willing to make the transition, **divas** themselves began to volunteer for transfer, heightening staff ambivalence:

Counselor M:

> I know that C. and S. asked to move and I agreed that they could handle it. But it was just crazy to have them both go so soon. At least one of them should have stayed longer to give some leadership. As it was the clients suffered the most.

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Counselor P:

> I felt the whole thing had gone wrong and the clients were getting caught in the middle. L. [the Director of Housing] and [Portals] administration were putting a lot of pressure on us that we had to respond to. When S. and C. both said they wanted to move it got really crazy. How were we supposed to react? They were taking away our most important people. I thought it was going to be bad and it was.

With this kind of social importance, it is clear that **divas** are accorded very high social worth status among Harlem House staff.

The "Deserving Needy"

So far, we have identified a number of sub-categories of continued stay clients who are accorded high social worth by staff because of active roles they play in the smooth operation of the residence or because they meet the staff's psychological needs by possessing personality traits or personal characteristics that staff highly value. The final sub-category of high social worth clients are those whom staff are dedicated to serving despite their considerable level of disability and their need for ongoing assistance. Staff most often refer to these clients as **the deserving needy**. These are clients who require a great deal of staff effort but who either gratify staff with their appreciative and cooperative attitude or, in some cases, who have strong external advocacy that staff responds to positively.

The sub-category of the **deserving needy** are identified by staff as clients whose needs and limited potential make them "lifers" at Harlem House. That is, staff acknowledge that these clients are not likely to ever make the transition to the next level of less supervised housing. In identifying clients in this sub-category, staff is accepting responsibility "forever" for a group of clients with extraordinary needs.

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At a baseline, such clients must cooperate and express a minimal level of gratitude:

> Residence Director A:
>
> In a way the really needy clients are our biggest challenge because it doesn't take long for staff to realize who will be with us for a very long time. Staff have to be willing to accept this level of involvement and know that it's going to be for the long haul. If these clients don't cooperate they're sunk. Staff won't make the commitment. So you really work on socializing them [the clients] to cooperate and to give staff positive feedback.
>
> Counselor J:
>
> I'll tell you the difference between someone like D., who was just a parasite and S., who has a lot of the same needs but he appreciates our [staff] efforts. D. gave back nothing, he was a blank. The only thing we got from him was more demands. The difference with S., who in some ways needs even more help than D., is in the attitude. S. always tries to cooperate...and you feel that he appreciates our help. This means a lot to the staff.
>
> Senior Counselor D:
>
> ...Take M., for example, we [staff] could tell from the beginning that she wasn't going to make it to scatter site, let alone graduate [two levels of less supervised] housing. And you know we had to make a choice about whether we would have her at Harlem House indefinitely. It was hard in the beginning because she had a nasty side. She never said thank you and needed so much help. She acted entitled and we [staff] weren't enjoying it ...But staff made the effort with her to be more sociable and after a while she got the idea and began to cooperate more and express her thanks. By the end of the first year the bond was formed.

"External" Advocacy for the Needy

External advocacy for **deserving needy** clients can have a significant impact on Harlem House staff's willingness to work with them. The research revealed three kinds of advocacy that staff respond to in varying degrees: advocacy by "outside" Portals staff

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(e.g., from the Day Treatment, Clinic, vocational and MICA treatment programs); advocacy by non-Portals professionals, such as Intensive Case Managers or "outside" treating psychiatrists or therapists; and advocacy by the client's family.

Virtually all Harlem House residents are involved in services at Portals. Most clients attend the Continuing Day Treatment Program and receive psychiatric services at Portals, many participate in Portals vocational rehabilitation programs and receive MICA treatment or individual psychotherapy services. Given this level of involvement, clients often have strong advocates among Portals staff. Joint case conferences between Harlem House and involved Portals staff take place on both a regularly scheduled and as needed basis and there is a structural level of accountability in which Harlem House staff participates as part of the clients' overall Portals treatment/service team.

Despite the formal structure and persistence of some Portals staff, Harlem House staff is only intermittently responsive to such advocacy. Most Harlem House staff expressed the belief that Portals staff often just "don't understand" the enormity of the task of working with **needy** clients. Although Harlem House staff views itself as being cooperative to the maximum extent possible with their Portals colleagues, they reserve the right to make and often do make decisions independently of this kind of advocacy.

The research found a number of instances in which Harlem House staff did respond positively to either a senior Portals staff member who possessed agency authority to intervene or to Portals staff with whom they had an acknowledged especially close relationship. The former instances elicited both feelings of resignation and resentment from Harlem House staff, who understand that senior Portals staff has the ability to

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intervene directly. Instances in which Harlem House staff was consciously trying to respond positively to staff with whom they work closely at Portals were more complicated. Harlem House staff acknowledge the importance of the MICA treatment and psychiatric services at Portals, for example, and they seek to accommodate such staff as often as possible. But while they acknowledge the risks of alienating Portals staff and cite examples of the negative impact of their "unilateral" decisions on their partnership with Portals staff, Harlem House staff nonetheless claim the right to make the "ultimate decisions" about the clients with whom they are working.

Professionals who work with Harlem House clients outside of Portals receive noticeably less consideration. Of all of the categories of outside professionals, Intensive Case Managers (ICMs) who are assigned to some identified Harlem House clients because of their "heavy" use of psychiatric inpatient and emergency services (ICM is a state-funded program) receive most consideration from Harlem House staff. This takes the form of frequent phone contact and face-to-face consultations. However, Harlem House staff view Intensive Case Managers more as support systems than as co-decision-makers. Staff report that while they feel obligated to process issues with Intensive Case Managers, that they alone have decision-making authority. Not surprisingly, other outside professionals such as treating psychiatrists or therapists receive minimal staff consideration.

A large majority of Harlem House clients have no family contact. Years of homelessness and mental illness have resulted in the severing of family ties for more than eighty-five percent of the residents. The research found, however, that having an

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involved family increases the likelihood that **deserving needy** clients will remain in residence. The quality of the involved family is an important intervening variable, although family involvement per se was found to have a beneficial effect. Those families of clients who have positive relationships with staff more easily secure open-ended services for their relative. More surprisingly, even those families that are less-well liked by staff are able to have a positive impact in securing ongoing status for their family member at the residence.

In exploring this area with staff, many spoke about their likes and dislikes of specific families they have worked with over the years. In general terms, however, even in discussing "meddlesome" or "over-involved" families, staff exhibited a significant respect for those families who are involved which clearly translates into an increased willingness to provide open-ended services to some very needy clients.

Clearly, staff prefer to work with families with whom they have positive relationships. Such families are granted a significant ongoing role in monitoring the client's welfare at the residence:

> Counselor K:
>
> S.'s family is really great. Every Sunday his sisters take turns coming here after church, sometimes all four show up. They usually bring us fried chicken or something for lunch. They're so close to S. it just makes us all feel good. So when they call during the week to find out how he's doing and [to] advocate for him we [the staff] are very responsive. When you consider that S. needs so much assistance constantly, the staff has been willing to give it to support him and his family.
>
> Senior Counselor D:
>
> S's family is the most involved I've ever seen at Harlem House. They care so much about him and are so kind to us [staff] and grateful to us that

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we are O.K. with giving him all the help he needs...and having his family so involved. They've been our partners in taking care of S.

More "difficult" families are viewed with some wariness, but are still given considerable respect which appears to increase the likelihood that staff will make a commitment to their family member at the residence:

Assistant Residence Director C:

L.'s family can be too involved; his mother especially can be very demanding. But I think that just having a family who cares has an impact on us [staff]. So many of the clients have no one and when someone does we try to go the extra mile.

Senior Counselor F:

When the family is "off" and a pain it makes it harder. Sometimes I get so frustrated with L.'s family I could just scream. But then I think that at least these people have contact and they care. We've talked about it at staff meetings and I think we basically agree to put up with it and to try to be as positive as we can be. No matter how difficult the family, I think we're more responsive [to the client] when they're in the picture.

Summary Of Continued Stay Roles

As indicated in Figure 5 the process of "selecting" continued stay clients involves the staff's material and psychological needs and the valued roles that clients play in the residence. The research found that in order to achieve continued stay status, clients must, at a minimum, work with staff cooperatively. Beyond cooperation, staff seek gratification when their efforts to nurture clients are rewarded with client progress in either improved daily living or relationship skills. To staff, this gratification represents the highest professional achievement.

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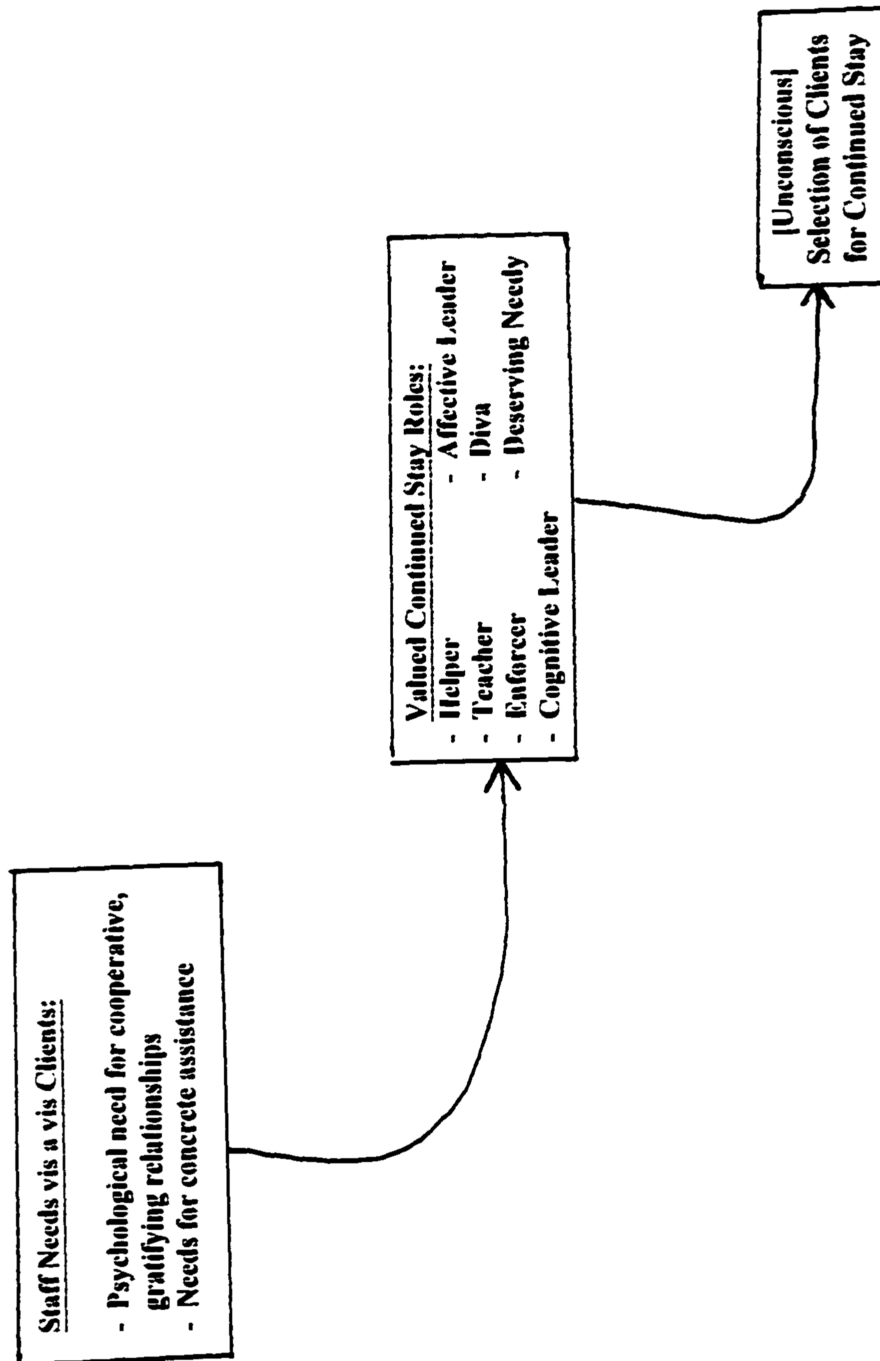
Figure 5. Selection of Continued Stay Clients



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The research also found a number of specific client roles and functions assumed by continued stay clients. High social worth roles include **helper, teacher, enforcer, cognitive leader, affective leader and diva.** Each of these roles plays an essential part in the maintenance of the smooth operation of the residence and in creating a "positive" sense of community.

The **needy,** clients who require intensive ongoing services, achieve continued stay status if they cooperate with staff and are able to express gratitude for staff efforts. Of all the external influences on Harlem House staff – Portals program staff, outside professionals and client families – the latter appears to be the relationship that most assures **needy** clients ongoing services at the residence. Positive and supportive families who express gratitude to staff are especially appreciated by staff, but even "difficult" families are accepted and promote the staff's willingness to work with their client-relatives.

The Client Perspective on Continued Stay

The researcher conducted interviews with nine continued stay clients to obtain their perspective on their long stays at Harlem House. For purposes of identification, clients are assigned individual numbers in the quotes contained in this chapter. The numbers correspond to the following client descriptions:

Client 1: 55 year-old African American female

Client 2: 34 year-old African American female

Client 3: 41 year-old white male

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Client 4: 38 year-old white male

Client 5: 36 year-old African American female

Client 6: 40 year-old African American male

Client 7: 44 year-old African American male

Client 8: 39 year-old African American female

Client 9: 43 year-old African American female

Several important themes emerged in the client interviews, revolving around two critical dimensions of the clients' experiences. First, clients described a progression of concerns and feelings relating to their overall adjustment to Harlem House and their evolving expectations. Secondly, they explored their perceptions of why they believe they "succeeded" in the program.

Clients' concerns and feelings as their stay progressed followed a discernible pattern. The dominant theme in the clients' early adjustment period was a concern for **safety**. Given the extended periods of homelessness and hospitalizations that most clients experienced prior to their move-in to Harlem House, clients were first and foremost concerned about being in a protected and safe environment. As we shall see, this concern more than any other shaped the clients' early perceptions of staff.

As clients "settled-in" and began to feel secure with staff and the community, a strong feeling of **"place"** emerged for many. From their perspective, clients viewed the program as an open-ended residential opportunity (the interviews confirmed that none of the clients was told on admission by staff that the program was transitional, with an expectation of movement to less supervised housing within the prescribed 24-month

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period). As months passed, most clients developed a strong sense of belonging to the program community, achieving a sense of **"place"** and security that they had not experienced for many years.

The third theme that emerged for some clients was a new and burgeoning sense of **"having a future,"** again a self-described unique feeling for those who experienced it. While this consciousness of and optimism about the future were not universally expressed, almost half of the clients spontaneously spoke about the future in positive terms and about specific goals that they hoped to achieve. For those who explored this area, the most common major goal was to establish an "independent" home for themselves, a prospect that was becoming a reality for many as they prepared to move to Portals "graduate" housing.

The second dimension of client perceptions that emerged in the interviews revolved around their ideas about why they succeeded in the program. The dominant theme to emerge in these discussions was an awareness of their self-conscious efforts to cooperate with staff and to "follow the rules." This attitude was so pervasive that the research likened it to an acute awareness of self in which clients were ever vigilant in their cooperative behavior. The interviews revealed that, for many, this attitude reflected an awareness of the risks of "non-cooperation" which might ultimately lead to devastating prospect of discharge, which they observed in the negative discharge of clients over the years.

On another level, this awareness of following the rules highlights the importance of staff/client relationships to continued stay clients. Beyond the issue of mere

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compliance, clients indicated how important their relationships with staff were, how working mutually with staff was satisfying to them and that staff were important role models for them.

Thus, several clients attributed their success to going beyond mere cooperation to their willingness to "do more" than the minimum and an awareness that they were creating positive bonds with staff and the program community. In this area, clients were often aware of their special roles in the residence, expressed pride in their contributions to

Harlem House and satisfaction in developing the positive relationships with staff that they and staff highly valued.

The Quest For Safety

Continued stay clients universally described their initial concerns as they contemplated admission to Harlem House. The common theme was the quest for a safe environment. In describing their initial pre-admission visits to Harlem House most clients indicated that they based their initial evaluation, not just on the physical aspects of the program (having their own bedrooms in shared four-bedroom apartments) or on their willingness to follow the rules and meet program "requirements" for community participation and cooperation, but mainly on the sense of safety and harmony evident in the program. The concern about safety revolved around two expressed dimensions for most clients: having a secure physical environment in which one's possessions would not be at-risk and being protected from the kind of physical danger they had lived with for so long in the streets or shelters.

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Clients clearly viewed staff as being primarily responsible for establishing and maintaining safety in the program. In describing their pre-admission visits to Harlem House all of the clients shared their early impressions of the staff. Their descriptions of staff during these first encounters captured these concerns:

> Client 6:
>
> When I went to dinner at Harlem House I knew what I was looking for: staff that would be understanding, non-judgmental, but firm and strong. I didn't feel safe for so long and I had been through so much I needed strong people. I met L. and A. [the Residence Director and Assistant Residence Director] that first night and I could tell that it would be OK.
>
> Client 3:
>
> I thought I'd be safe at Harlem House, that was the most important thing. I saw the apartment and had dinner... I saw the staff and members together and I thought the staff were like Gods because they were so in control in a good way. The members weren't scared, they were kind of mellow...everyone got along together.
>
> Client :
>
> When I first went to Harlem House I looked at people's eyes. No one was afraid. Staff was in control...and the members looked happy and...safe.

A Growing Sense of "Place" and A Future

Most continued stay clients described a growing sense of security as their stays lengthened and their attachment to the residence, staff and other clients developed. Several clients spoke about how well staff and clients "clicked" with each other, the strong senses of community and the bonds created through sharing "the good times." As clients' feelings of security grew they increasingly viewed the program as their "place" to

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be. This feeling was often reflected in the care and attention that clients increasingly directed to both their physical environment and relationships at the residence.

> Client 2:
>
> I thought we should call it "Party House" because we had so much fun. We always had something to celebrate...I knew it wasn't my own place really, but in a way it was better because it was somewhere for me to have fun with other members and the staff...After a while, I took my own money and bought some things for my room to add to the Portals stuff...It was more like home.
>
> Client 9:
>
> We all worked so well together, members and staff, we just clicked. We cooked together and helped each other. And when there were problems we talked about it and you knew where staff was coming from. It was the best time. I felt great and that I belonged; it way my place.
>
> Client 3:
>
> I didn't have my own place for years and Harlem House became it. L. and A. [the Residence Director and Assistant Residence Director] were the best and I made friends. I could get mad and not feel so good and even go a little crazy, but I knew I'd get over it and that I'd still be here.

In the course of the interviews, four out of the nine clients interviewed spontaneously indicated that as their stay lengthened and their sense of security deepened they began to think in a new way about their lives; they began to develop a sense of "having a future":

> Client 6:
>
> Feeling that I have a future is new... It's what I got at Harlem House.
>
> Client 1:
>
> I had my nightmare years homeless and in the hospital...I never thought about the future then, every day was just about making it...Now I'm having a future and I'm looking toward it.

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Client 8:

I was talking to D. [Senior Counselor] one day, telling her about my mother and daughter and I realized that I could have a different relationship with them now, if I could find them. I have my goals now. I'm not just existing…I'm thinking about the things I want to do.

Client Reflections on "Success"

In reflecting on their success in the program, clients above all else stressed their cooperative attitude and attentiveness to complying with the rules and staff directives at the residence. In doing so, clients clearly viewed their success as first and foremost stemming from the positive relationships that they developed with staff over time. And, while the client responses were often expressed rather simply and even naively, they nonetheless reflect the clients' essential understanding of the importance of cultivating and maintaining positive relationships with staff. To clients, at the core of this relationship was their compliance and cooperation with staff's demands. Virtually all clients interviewed expressed their belief that they succeeded in the program primarily because they cooperated with staff and "didn't make trouble." Clients described their awareness of this issue and their vigilance in maintaining cooperative behavior:

Client 4:

I made sure I had no problems or arguments with anyone. My idea was as long as I cooperated and kept my cool I would be OK... I followed the rules and tried not to argue with anyone. I saw people in trouble and arguing and I stayed out of their way…My idea was just maintain a half-decent lifestyle and you could stay.

Client 3:

I bathed and did my chores and my laundry and followed the rules. I stayed a long time because I didn't get into any trouble.

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Client 8:

I did well because I followed the rules. I was good; I didn't give anybody any trouble. I didn't agree with everything staff did but I accepted it and it turned out O.K.

Beyond this perception of the importance of their baseline cooperation, most clients acknowledged the importance of the positive relationships they formed with staff and saw these relationships as being both personally satisfying and a key to their progress in the program:

Client 1:

I truly loved L. and A. [the residence director and assistant residence director] and I think they loved me. They taught me so much and took good care of me. I gave them as much as I could...help[ing] [them] whenever I could. I felt blessed to have them.

Client 2:

I was too happy at the residence, cooking and having parties and laughing. I was very close to D. [counselor]. When we had ADL visits [weekly meetings in the apartment focused on daily living skills] we had so much fun. He taught me a lot and I learned a lot...He's my main man; whenever there was a problem I knew he would help...as long as he was there I would be able to stay as long as I wanted.

Client 5:

...the staff made the difference. You could count on them and after a while I felt really good because they could count on me. I checked out how others [clients] did it and I tried to do it the same way; help out staff, really work with them.

Client 7:

The staff were so incredibly supportive. They accepted me, that's what I felt was most important. And when I got close to them it made all the difference...having their help and support... It made me strong so I could get it together.

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In addition to cooperation and forming positive relationships with staff, four of the nine clients viewed their success as a reflection of the special roles they played in the residence:

> Client 1:
>
> I did a lot of little things for staff...going to the store and helping with parties. They encouraged me...and I started to take an interest in helping others in the program. I would tell them: "fix up your mind instead of spending your money on trash." When I would see people messing up I would say, "you get your life together, it's worth it." Staff approved, they would ask my opinion at the [community] meeting... I helped turn people around...and staff got on my side.
>
> Client 9:
>
> I know I did extra. I never turned down a chore when they asked me to do one. I didn't mind working and I knew that staff appreciated it and counted on me.
>
> Client 6:
>
> I was a leader, but I always tried to lead with staff approval. I didn't push I led. I showed the other clients "how" and staff was responsive and supportive.
>
> Client 2:
>
> I loved cooking and planning dinner. Really I could have cooked three or four nights a week if they let me. What I loved doing gave me a special place with staff. We worked so well together and I was so happy that I could give something that they appreciated.

Thus, we see the idea of **relationship** at the core of most continued stay clients' perceptions about why they succeeded in the program. The clients' responses revealed that maintaining positive relationships with staff not only secured them ongoing participation in the program, it also provided the basis for their achieving personal growth and change. Clients clearly saw their relationships with staff as being the touchstone of

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their achievements in the program, whether it was in developing concrete independent living skills, such as apartment care, budgeting or self-medicating, or forming personally satisfying relationships at or outside of Harlem House.

Chapter Summary

In this chapter we have reviewed the phenomenon of **continued stay** as the third possible outcome in social programs. We explored both staff and client perspectives in this area. From the staff's perspective, in order for a client to achieve continued stay status, he or she must exhibit baseline cooperative behavior. Staff reported that they view themselves in a quasi-parental role (as nurturers and teachers) and that they are most gratified professionally when they observe client "progress" (as reflected in the acquisition of new daily living or relationship skills).

Beyond basic cooperation, the interviews revealed that there are a number of roles within the residence that confer high social worth status on some clients. These include **helpers, teachers, enforcers, cognitive leaders** and **affective leaders,** including **entertainers.** Staff acknowledge the importance of these roles in achieving and maintaining a smoothly functioning program and in gratifying their their psychological needs for a satisfying work life. Helping and leadership qualities in clients are nurtured by staff who acknowledge benefiting from the concrete assistance that many clients offer in the day-to-day operation of the program. The **diva**, a female client who assumes the fully realized role of a multi-dimensional mother figure who nurtures, teaches and enforces, is a centrally important figure in the residence. Given the influence that **divas** have in the program, staff must monitor their behavior closely. In regulating **diva's**

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problem behaviors, staff take a firm stance but consciously attempt not to undercut or diminish the essential role that these clients play. The discharge of **divas** from the program is often a destabilizing experience for staff and clients alike. Staff feel the loss acutely, eagerly awaiting the emergence of a successor.

Finally, we saw that the staff attached high social worth to the **deserving needy**, a group of clients that presents special challenges. These clients are not expected to be able to "graduate" to the next level of independent housing because of their inability to acquire the necessary skills. Thus, their stay at Harlem House is expected to be of indefinite duration. Such clients, who require considerable staff attention because of their limited abilities, can achieve staff acceptance and even high social worth status if they cooperate with staff and if they express gratitude for staff efforts.

In exploring the staff's relationships with the **deserving needy**, a common theme emerged relating to the role of external advocacy in affecting staff attitudes towards clients. Staff identified three major "outside" advocacy groups: staff from agencies outside Portals, Portals staff and clients' families. The latter, family advocacy, was found to have the most direct impact on Harlem House staff. Thus, while Harlem House staff was least responsive to non-Portal staff and only intermittently responsive to Portals staff, family involvement was found to contribute to staff willingness to accept and work with clients in an ongoing fashion. Staff identified two kinds of families, "meddlers" and "positive supporters." Significantly both kinds of families are given respect by the staff and although they prefer to work with "positive supporters," families that are viewed as intrusive and "difficult" are effective in securing a commitment to their client-relative.

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We next explored the client perspective on their continued stay status. Interviews with nine clients who had resided in Harlem House for more than thirty months revealed some important common themes. Clients described a progression of feelings as they were admitted to the program, as they "settled in" and as they achieved long-term status. The **quest for safety** dominated these clients' early concerns. In evaluating Harlem House prior to admission, most clients focused on the atmosphere of staff-client relationships they observed as much as the physical environment of the program. Given their previous homelessness their concern for physical safety is understandable. Beyond this, however, they also reported observing the clients and staff during their pre-admission visits. Their commonly expressed concern was for a strong staff that would establish a safe environment. Most comments referred to their pre-admission visits as a time when they were looking for indications that staff were firm, clearly in charge and protecting the physical well-being of the clients.

As clients "settled in" to the program and a senses of security was achieved, they began to develop a sense of the program being **their place**. This was described as a growing sense of confidence and even "ownership," reflected in both their participation in the community life of the residence and in their personalizing their space in their apartments (decorating, etc.). The sense of having a place that several clients described and the feelings of security that accompanied it were unique feelings that most had not experienced in many years.

For almost half of the clients interviewed, the experience of being in the program culminated in their feeling of **having a future**. At a baseline these clients saw their lives

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as having been transformed from the days in which they were consumed with the struggle to survive homelessness and the effects of their mental illness. In the course of their long-term stay at Harlem House, these clients reported having concrete goals for the future (i.e., jobs, independent living, new relationships), while some were simply content to be in the residence and in program at Portals. The strong commonality, however, was the expressed sense that they now had a future and could think about themselves as being active participants rather than passive victims.

In the last section of the chapter we explored continued stay clients' perspectives on why they thought their stay continued for so long (which they characterized as "success"). Their responses revolved around three major themes. First, virtually all articulated an intense self-awareness regarding their consciously cooperative behavior with staff which "kept them out of trouble" and assured them ongoing participation in the program. Secondly, most clients saw the positive relationships they formed with staff as central to their success. Finally, about half of the clients had an awareness of their special roles in the residence. They expressed satisfaction with these roles and pride in their contributions to positive community life.

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CHAPTER 9

Program, Policy and Research Implications

In this final chapter we will consider the program, policy and research implications of the study. Tying together the main themes from the findings, we will explore the findings from three major perspectives: program improvement and design; broader public policy concerns; and the implications for social work research, particularly evaluation research of ongoing social programs.

The central finding of the study, that a largely unconscious social process occurs in ongoing social programs which has a profound effect on client outcomes, should be noted at the outset. Since this fundamental reality is of such great importance in considering the implications of the study, we will first consider the phenomenon itself.

Staff and Social Worth: A Largely Unconscious Process

In framing the research questions for this study the researcher hoped to gain an understanding of the pattern of client outcomes at Harlem House: negative and positive discharges and continued stays. During the early interviews with staff, the researcher was puzzled by a seemingly inexplicable pattern of outcomes. For example, there were a number of instances in which clients who "broke the rules" in identical fashion were treated by staff very differently. The same act that would result in immediate discharge for one client was forgiven in another, who might be given several "second chances," often over long period of time, before staff even began to consider discharge. Thus, neither the rules themselves nor other obvious "independent variable" (i.e., medication

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compliance) could readily account for differential outcomes. The odyssey in conducting the study was the emerging understanding of the embedded social system and social process that exists within the program. This awareness occurred gradually as the researcher began to understand that the staff was largely unaware of it. While many staff members spoke articulately about the individual clients and readily "told the stories" of each client's participation in the program, there was virtually no awareness of the ways in which the staff unconsciously "sorted" and "categorized" clients, a process that had a profound impact on client outcomes.

During the interviews, some staff commented spontaneously on their own sense of confusion regarding the pattern of discharges:

> Assistant Residence Director C:
>
> I know that sometimes we give them [the client] slack and sometimes we give them "the sack"...As a rule, we [staff] don't really, choose, consciously anyway, to like one client over another. But there are some clients who grow on you and some who don't. When you like a client you stick with them through thick and thin. It's not always the best client; sometimes it just happens.
>
> Counselor J:
>
> You know we have so many types here. Sometimes when I think about who we discharge and who stays I get so confused. In hindsight, I try to figure it out. I know that some clients get chance after chance, while others are O.U.T. (her emphasis) the first time they do something wrong.

The researcher came to liken this process to **counter-transference** in the clinical sphere. As such, it merits close attention and understanding since it has such direct impact on client outcomes. Making the social process explicit to staff is essential to the

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establishment and maintenance of competent, reflective practice in the program, just as the individual clinician must be aware of counter-transference.

As we have seen, the phenomenon posited by Hasenfeld (1983), assignment of social worth to clients by staff and the impact of this assignment on client outcome, is clearly present at Harlem House. The "typification" process through which social worth is assigned is perhaps more complex than Hasenfeld suggested. Granted that the process at Harlem House revolved in large measure around the client's individual traits and characteristics, as Hasenfeld suggested. But there was clearly an underlying dimension to the process of assigning social worth: a client's potential or actual contributions in helping to achieve or maintain the community's norms and practices. When this second dimension was revealed, a dimension that staff were universally unaware of, the focus of understanding shifted to an important degree from the individual traits of clients to the largely unexamined needs of the community.

In this sense the findings evoke the discussion in Chapter 3 of Etzioni's (1960) distinction between production or super-ordinate goals and maintenance goals. Social programs seek simultaneously to achieve positive change in clients so that they can live more independent, productive lives with less future dependence on service (the production or super-ordinate goal), while, at the same time, perpetuating themselves through achieving necessary maintenance goals. Maintenance goals are often conceptualized as revolving around meeting the demands of outside environmental forces (i.e., regulatory and funding requirements). This study demonstrated the importance of "internal" maintenance functions, that is, meeting the staff's material and psychological

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needs. Thus, the two kinds of goals, "changing" clients (the super-ordinate) and meeting staff needs (the maintenance) are simultaneously present.

That this reality needs to be explicitly understood was vividly demonstrated in the review of positive discharges in Chapter 7. From 1990 to 1995, before external environmental forces placed pressure on the program to "transition" some clients from the program to less supervised housing, there were virtually no staff-initiated positive discharges. An obvious conclusion with far-reaching implications for managers of social programs is that the relationship between super-ordinate and maintenance goals must be carefully monitored. In the case of Harlem House we saw how staff placed greater importance on maintenance goals (i.e., having a smoothly functioning program), relying on clients for material and psychological gratification, than on the primary super-ordinate goal.

Again, these findings evoke an analogue in clinical practice. We may refer to the relationship between super-ordinate and maintenance goals as either **syntonic** or **dystonic**. In the case of Harlem House we saw how maintenance goals often overrode the primary super-ordinate goal, client transition to less supervised housing, reflecting a **dystonic** relationship between the two kinds of goals. Thus, even though staff expressed considerable gratification in observing client "progress" (clients achieving stability or acquiring new living skills), their attachment to such clients and the key roles that many such clients assumed in the residence clearly assumed greater importance to staff than the primary super-ordinate goal of the program.

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Thus, the research found that staff and clients alike saw great value in the relationships and attachments they formed with on another. Clients reported directly that they attributed their success in the program largely to the relationships they developed and maintained with staff. Similarly, staff reported significant professional and personal satisfaction in their relationships with clients. However, we have seen that the concept of the **relationship** between staff and clients could be used either to promote the rehabilitative goals of the program (a **syntonic** use) or to thwart them (a **dystonic** use).

For example, the discussion of impact of the "positive" discharges in the pre-graduate housing period highlighted the staff's reluctance to allow clients to move on. This is not surprising given the staff's attachment to the clients who performed positive roles in the program. Staff's expressed rationale for this cautionary attitudes was their concern that clients might fail (the "what if..." rationale). Yet we understand that beyond their concern for client protection was a fear of losing valued clients and the roles they played in meeting staff's material and psychologocal needs. Here then we see a **dystonic** relationship between the program's super-ordinate goals and staff's maintenance concerns.

Similarly, the discussion of the discharge of **divas** and other client leaders in Chapters 8 highlighted the same kind of **dystonic** relationship. The staff's feelings of loss and bitterness about the discharge of three client leaders within a short time, and their feeling of discontinuity and fear because the "client culture" had been severed and would need to totally reconstructed, are vivid example of the sometimes **dystonic** relationship between super-ordinate and maintenance goals.

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In developing an understanding of the pattern of outcomes it is necessary, then, to go beyond a mere consideration of client traits. The role of clients in meeting the staff's needs was found to play a significant part in individual client outcome. Specifically, a number of **protective roles** were identified which could mitigate against negative discharge of clients with negative traits. These roles add significant explanatory power in understanding outcomes. They clearly suggest why two clients who committed the same infraction would be treated differently by staff.

Similarly, as we have seen, such roles could even mitigate against positive discharge of clients who were ready for less supervised housing. In the period 1990-94, in the absence of external pressure to discharge able clients to less supervised housing, such clients, who played key roles in gratifying staff needs, were usually assigned to "continued stay" status. This significant undermining of the program's primary super-ordinate goal, was only addressed by the external pressure of senior management that began in 1995.

Figure 6 illustrates the relationship among client traits, client roles and outcomes. The figure illustrates how client roles become a crucial intervening variable, having a powerful impact in shaping individual outcomes.

Revealing these dimensions of the social process at Harlem House is crucial not just for staff, but for clients as well. As described in Chapter 8, continued-stay clients often attributed their longevity in the program to their "good behavior." While some clients were aware of their special role in the program, all expressed the simple belief that

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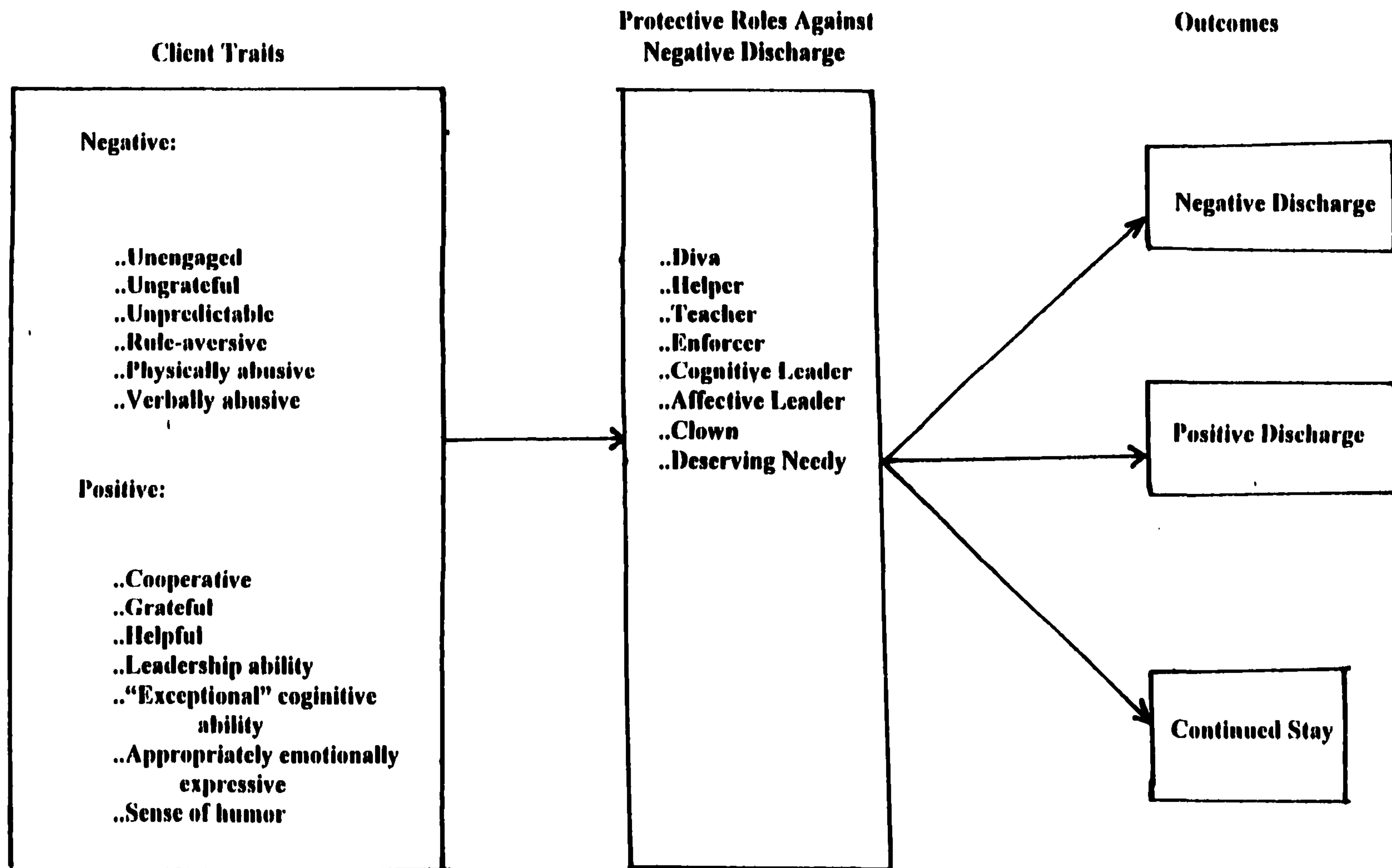
Figure 6. Potential Relationships Among Client Traits, "Protective Roles" and Client Outcomes At Harlem House



"staying out of trouble" was the most important way to protect themselves from discharge.

In light of the discussion of the unconscious nature of the social worth "typification" process and its direct impact on outcomes, it is understandable that clients would view their success in such concrete terms. The fact that "bad" behavior could lead to different outcomes (negative discharge, continued stay) must confuse clients on an unconscious, if not conscious level. And while we have seen that clients rarely directly challenged or initiated a negative discharge, one might understand their confusion. Their only safe haven, then, was to rigidly maintain their own "good behavior," given the staff's sometimes unpredictable behavior. While "good behavior" may be desirable for the overall positive functioning of the program, unexplored client confusion, whether conscious or not, mitigates against the kind of growth and development which are strongly related to the primary (super-ordinate) goals of the program.

"Scanning" and "Self-Correction"

With so much at stake in terms of the fate of individual clients, it is essential that the largely unconscious social worth process be addressed directly by staff at Harlem House and its parent agency, Portals. The approach here would be to make staff at the residence aware of these phenomena and to establish an ongoing mechanism to "scan" the program from this perspective so that "self-correction" can occur. The dual purpose here is to encourage and affirm the **syntonic** use of relationships as the key to client growth and development, while discouraging **dystonic** relationships to minimize their negative effects on clients (i.e., holding clients back, pushing clients out).

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This effort should begin with staff training and orientation. The reality of social relationships and patterns in the residence should be thoroughly reviewed with new staff and should be treated with equal importance as other training/orientation topics. Staff should understand the importance of staff/client relationships as the touchstone of client growth and development and should be exposed to the overall pattern of social relationships in the residence as a dynamic that has a direct impact on client outcomes and is a subject of ongoing concern.

The program's supervisors and manager have a special role to play in the "scanning" and "self-correction" processes. As senior staff, they have primary responsibility on-site to address the unfolding social patterns within the program and to engage the staff in a reflective process to understand and shape them in a manner consistent with the program's super-ordinate goals.

Since the realities of the social worth and "typification" processes exist in all of the agency's programs, Portals management also has a role to play in assuring that they are addressed. Senior housing management staff and Portals central administration should incorporate these concerns into their management strategy, both in formal evaluation policies and procedures and in establishing mechanisms to assure that relevant issues are aired and addressed within all programs.

Clearly, social worth and the "typification" process are naturally occurring phenomena in social programs, reflecting patterns of staff and client interaction over time. Because these phenomena relate directly to individual staff member's material and psychological needs as well as the program community's overall needs, they are expected

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to exist in all programs and cannot be eliminated. The effort that is needed, then, is not to eliminate them, but, through awareness and reflection, to understand their impact on client outcomes and how they can be used to support the program's goals. The findings of this research demonstrate how important this task is.

Other Program Design and Improvement Implications

Beyond the implications of the importance of revealing the underlying social process within the program, there are a number of concrete program design implications suggested by the study. These fall into three major categories: admission/screening policies and procedures; establishing client expectations regarding transition; and staff attitudes towards and participation in the negative discharge process.

Screening and Admissions

As we have seen, the preponderance of negative discharges revolve around a set of specific client behaviors and attitudes (substance abuse, non-cooperation with fees and other basic expectations, persistent verbal abuse, physical violence, clients whose functioning is so poor that they require constant staff assistance and attention for even the most elementary tasks). This suggests that effective screening of potential clients at the time of admission is essential.

Since the mid-1980s, Portals has maintained a transitional day program for the homeless from shelters; in the mid-1990s a second transitional program to serve street homeless was added. Through these programs, clients participate in a number of low-demand, nurturing activities that prepare them for the more structured demands of living in a residence or participating in a formal rehabilitation program. While these transitional

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"readiness" programs are effective in "screening out" some clients who clearly would not do well at Harlem House, a serious limitation has arisen.

Over the past few years, staff in public shelters has come under increasing internal pressure to place clients as quickly as possible in community residential settings. This has meant that potential Harlem House clients are spending only two to three **weeks** in the Portals transitional day program before their residential placements in contrast to the four to five **months** which was the previous norm. With admission decisions being so rushed, there is considerably less time for clients to be socialized into the agency and its values and for staff to make complete assessments. The results are evident in recent Harlem House discharge data, which document an increased number of discharges in recent years shortly after admission.

A similar situation exists with homeless clients who are referred from inpatient psychiatric units of municipal or voluntary hospitals. Whereas previously hospitals were willing to have clients attend the transitional day programs for several weeks prior to discharge to the residential programs, the drastically reduced lengths of inpatient stay that are common today does not allow for this transitional work and necessary assessment process. Hospitals today typically expect discharge within a few days of admission. Again, this means that there is little time for assessment or transitional work.

In the absence of the extended "intake" and assessment through the transitional day programs, a more formal assessment at Harlem House is advisable. The previous admission routine at Harlem House was rather informal, usually consisting of a single interview with staff and the potential client having dinner at the residence. This kind of

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informality was appropriate given the "pre-screening" that occurred in the transitional day programs. Now, however, with such a compressed admission process, Harlem House should institute more formal psychiatric and functional assessments, as well as substance abuse screening.

The issue of substance abuse and its role as a major contributor to negative discharges are of special concern. Harlem House is not designed for clients with co-occurring mental illness and substance abuse. It lacks the structure and resources needed for such a program (at a minimum, on-site treatment services provided by Certified Alcoholism and Substance Abuse Counselors and a modified therapeutic community structure). The challenge of providing residential treatment for the homeless persons with co-occurring mental illness and substance abuse has obvious public policy implications that will be discussed below. In the current context, it is essential to note Harlem House's limitations in this area and to increase efforts to "screen out" potential clients with serious substance abuse problems.

Transitional Expectations, Fees and Program Participation

Efforts at admission to clarify client expectations regarding occupancy and participation at Harlem House are also needed. The first major concern in this area is clients being informed "up front" that Harlem House is not permanent housing and that it offers them a program that is likely to lead to a housing transition within three years. Creating this understanding is an important first step in helping clients assess their own interest in the program and willingness to participate.

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In the interviews for this study several staff expressed a reluctance to address transitional expectations with clients at the time of admission because they feared that expressing such expectations might increase potential clients' feelings of hopelessness or "scare them away." These staff were concerned that the homeless in particular might react negatively if, at the same time that they were being offered housing (and hope), they were also being told that it would be for a limited time. While one can certainly understand this concern, it is suggested that the idea of transition can be presented as a "positive," offering clients the sense that they will have an opportunity to participate at Harlem House and in programs at Portals that will assist them in developing the kinds of skills they need to make a successful transition to more independent housing. The problem with not addressing transitional expectations upon admission is that clients quickly adopt the belief that Harlem House is a permanent housing program.

Along the same lines, given the compressed admission process, other important client expectations, such as the fee structure, "chores" and community participation, must be fully explained prior to admission. The interviews for the study found that clients have played an important part in orienting those who are newly admitted. While this practice should continue to be encouraged, we have seen that some areas require more direct staff input to clarify expectations.

The client fee structure is the most salient example in this area. Several discharges occurred because of misunderstandings about the fee structure and how fees are collected. Since this is such an important area of potential conflict, it is essential that staff conduct a fee orientation prior to admissions for all new clients.

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Staff Attitudes Towards and Participation in Negative Discharges

Some of the most salient findings of the study were in the area of staff attitudes towards discharges. We saw in Chapter 6 that staff view negative discharges as "life or death" decisions. To staff, such discharges mean the return to homelessness and psychiatric disorganization for clients. We also saw that all levels of staff expressed the strong need to participate effectively in the discharge process.

The burden of making "life or death" decisions about clients clearly weighs heavily on staff. While in one sense this may have a beneficial impact on the program (proceeding cautiously with the discharge process), it is also clear from the interviews that staff carry a significant burden of guilt in the negative discharge process. It is suggested that the staff be engaged in an ongoing process to explore and address these feelings.

As we saw in Chapter 6, one way in which to minimize the burden of staff guilt is to have a fully participatory negative discharge process. The negative discharges that were regretted the most by staff were those which they felt were "imposed" by either the residence director (without the customary staff input) or by Portals management. The findings suggest that in residential programs for the mentally ill homeless, negative discharge take on an especially charged meaning for staff. Full participation in the discharge process by staff at all levels of the program is necessary to ameliorate potential guilt feelings associated with such discharges.

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Public Policy Implications

While this study focused on the internal operations of Harlem House, two of the findings relate to important public policy issues. Before discussing them it might be helpful again to locate the Harlem House program within the continuum of services for the mentally ill homeless.

As part of their response to the greatly increased number of mentally ill homeless in the late 1980s, The New York State Office of Mental Health, New York City Department of Mental Health, Mental Retardation and Alcoholism Services and the New York City Human Resources Administration (which operates the City public shelter system) promulgated the "New York/New York Agreement" to develop community-based residential alternatives to shelters. Under this initiative, three kinds of housing were developed: 24-hour supervised, single-site community residences (intensive transitional programs of which Harlem House is an example), supervised scatter-site housing (also a transitional program in which clients live in conventional buildings and are visited between one and seven times weekly by a mental health case manager); and supported housing (permanent housing with minimal case management services). In view of the high cost of the 24-hour supervised residences, it is not surprising that the fewest number of beds were developed in this category. The overwhelming majority of beds that were developed (and will be developed under the "New York/New York 2 Agreement" signed by the State and City in the spring of 1999) were in the supported housing (or least supervised) category.

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The findings of the Harlem House study offer a limited commentary on this continuum of residential services. While we have seen that the relationships between staff and clients at the residence can sometimes be used in ways that negatively affect clients, we have also seen that clients and staff attribute "true" client success in the program (as measured by the acquisition of independent living skills and abilities) to the relationships they share.

This finding recalls the discussion in Chapter 2, which reviewed three models of "excellent" programs for the mentally ill homeless. One model stressed psychiatric services only, the second stressed the provision of housing and other concrete services, the third stressed re-formulation of personal attachments as the basis of rehabilitative efforts. The Harlem House program, as described by staff and clients, most closely resembles the third model, offering clients an opportunity to use relationships as the foundation for rehabilitative growth. While the study of Harlem House was not designed to judge the overall success of the program in preventing the return to homelessness (which is certainly the minimal goal of any residential program for this population and which might serve as the basis for comparative studies of the various residential and program models), the strong conclusions reached by clients and staff about the importance of relationships and attachments in the program are noteworthy. They suggest that meaningful relationships and attachments are important rehabilitative program elements and that programs which offer concrete services only (i.e., psychiatric services, housing) might be less effective in preventing the return to homelessness or

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promoting rehabilitation. Again, this is an empirical question to be explored in future research.

A second important public policy issue raised by the study relates back to the debate about the framing of the homeless problem among policymakers. During the late 1980s, as governments at all levels were preparing responses to what was perceived as a crisis situation, advocates for the homeless attempted to portray them in as positive a light as possible in order to gain both public sympathy and access to public funding. In reviewing the literature in Chapter 1, we noted that two basic approaches in framing the problem of homelessness were offered: the first was that the explosion in homelessness was a direct result of state mental health policies, specifically the deinstitutionalization of the mentally ill. A second framing viewed the homeless as the victims of major economic shifts in the nation (the loss of millions of manufacturing jobs), combined with the suspension of the federally-funded public housing construction.

Advocates for the homeless appear to have consciously avoided an important reality about the homeless, the very high rate of alcohol and substance abuse, perhaps out of fear of alienating the public from their cause. The result was that the programs that were developed did not directly address this important treatment dimension.

The experience at Harlem House reflects this problem, which has also been reflected in other research nationally (see especially Hurlburt et al, 1996). As we saw in Chapter 5, virtually all residents of Harlem House have a diagnosis of major mental illness. With rates of co-occurring substance abuse running as high as 85%-90% among this group, program planning and funding must clearly address this issue. Unfortunately,

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in New York State, they did not. The result is that the largest number of negative discharges from Harlem House were attributed to substance abuse (clients using/selling drugs/alcohol and/or their collateral behaviors such as stealing, verbal and physical assault).

This reality underscores the necessity to address substance abuse issues in the design and funding of residential programs for dually-diagnosed clients, particularly those programs that are providing either residential or rehabilitation services to clients who have most recently resided in shelters or been street dwellers. Program design must include substance abuse treatment components, including staffing patterns that include certified alcoholism and substance abuse counselors. Residential staffing should also be enhanced to provide the additional supervision and structured activities that dually-diagnosed clients require. And such expenses as random drug screening should be routinely funded. In the absence of these design elements and ancillary services, residential programs for the mentally ill homeless will continue to have high discharge rates relating to substance abuse.

This is an especially difficult challenge given that the structure of State government divides responsibility for the mentally ill and substance abuse populations. In order to address the needs of these dually-diagnosed clients, the New York State Office of Mental Health and the Office of Alcoholism and Substance Abuse Services will have to forge a positive collaboration. To date, such a collaboration has not occurred. It is noteworthy, however, that the two state agencies recently entered into a Memorandum of

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Understanding which has committed them to working together to address the needs of the dually-diagnosed.

Implication for Social Work Research

This study of client outcomes at Harlem House has significant implications for social work researchers. In Chapter 3 we reviewed Egon Guba's (1990) typology of contenders to the position once so securely held by Cartesian positivism (the belief that certain knowledge exists and is knowable through "objective" methods). Of the three emerging paradigms, **post-positivism** (objective reality exists but is impossible for imperfect humans to comprehend; researcher objectivity and research methods are similarly circumscribed), **critical theory** (which grants objective reality but substitutes an ideological lens through which to discover it) and **constructivism** (which views both reality and the techniques for knowing it as relativistic or heuristic "constructions"), the researcher adopted the latter stance.

Quantitative methods did not seem to be appropriate for a study that was attempting to understand both individual client outcomes and to determine if there was an overall pattern of outcomes. What variables could be specified deductively? How could one go about positing a relationship among them? The use of inductive inquiry and qualitative methods seemed best-suited to the task of trying to develop the understanding that was being sought.

Although inductive qualitative methods were employed, for heuristic purposes the researcher used an **orienting concept** (social worth), that was deductively derived. This combination of inductive method, with its emphasis on exploratory knowledge-building,

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together with an orienting concept, is an example of Guba's (1990) **constructivist** at work.

As government at all levels continues to scrutinize social programs more closely, outcome measurement and outcome studies have achieved new importance. A sea change is occurring as government shifts its evaluation of social programs from **process measures** (i.e., number of clients served, number of staff hours provided) to **outcome measures** (number of clients achieving the program's super-ordinate goals). In order to maintain their claim on public funding, social programs will increasingly have to demonstrate outcome effectiveness.

The study of Harlem House sheds important light on the factors that shape outcomes in residential programs for the mentally ill homeless. These same factors probably apply to other residential programs and long-term outpatients programs, such as day treatment. With the knowledge gained from the study of Harlem House, agencies and program managers can better address ways in which to maximize program effectiveness.

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APPENDIX 1 - INTERVIEW GUIDES

INTERVIEW GUIDE #1 - Staff Interviews on Discharges

Preamble:

The purpose of our meeting today is to talk about one of the important aspects of the program at Harlem House. Since you work in the program day-to-day, I think you are in an excellent position to think about how the program runs, to identify problems and to think about possible solutions. I'm going to interview everyone on the staff and after all the interviews I'll share the results with you.

As you know, I have an important position at Portals. But, I'm not here today to judge your or anyone else's performance on the job. There are no right or wrong answers and everything you tell me will be totally confidential. I'm doing this research as part of my doctoral dissertation.

Harlem House operates pretty independently. Bob and Desiree report to Lou Cuoco, who has much more day-to-day concern with how the residence operates than I do. The aspect of the program I'd like to discuss today is the discharge process. I know that discharges often cause strong feelings in the staff and clients. Sometimes these are positive feelings and sometimes negative. I think that the discharge process is important because the reasons and the way people are discharged can have strong effects, not only on the client being discharged, but on the other clients and on staff, too. It's important for us to look at the discharge process to see how it's usually handled and if there are any problems that should be dealt with.

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Questions:

1. Let's start by talking about a recent discharge. In March, "client X" was discharged. What kind of person was "client X"? Let's talk about his/her time in the residence. Probes: a) relationships with staff; b) other clients; c) use of program at residence; d) at Portals.

2. Can you tell me how "client X's" discharge came about? Probes: chronology of events -- What occurred, when and who was involved.

3. In your opinion, then, what would you say were the reasons that "client X" was discharged?

4. Let's focus for a minute on the "final decision" that was made to discharge "client X." Can you tell me how the decision was made? Probes: a) were you directly involved in the process?

If yes, how; b) if not, how did you learn about the final decision and what was your reaction?

5. It's now been "X" months since the discharge and your feelings now about the discharge may be the same or different from what they were. What were your original feelings and what are your feelings now? Probe: if feelings have changed, explore why.

6. When someone is discharged there is sometimes agreement among those involved and sometimes there is disagreement. In the case of "client X's" discharge, who supported the discharge and how did you know they supported it? (review list: Residence Director, Assistant Residence Director, Senior Counselor, the Counselor assigned to the client, other Counselors, clients, other Portals staff, family friends, collateral professionals, etc.).

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Probe: In your opinion, who didn't support or was opposed to the discharge and how did you know they opposed it?

7. Can you tell me what happened to "client X" after the discharge? What have you heard?

8. How do think "client X's" discharge has affected the staff and other clients at Harlem House?

9. Now that we've reviewed "client X's" discharge, let's talk about some others. (review list) Probe: are there any particular discharges that stand out in your mind? Tell me about them.

10. Now that we've reviewed a number of discharges, let's talk about the discharge process in general. Is there anything about the discharge process that you haven't mentioned so far that stands out in your mind? Probe: (for long-time staff, 2+ years). Over the time you've worked at Harlem House, describe any ways in which you think the discharge process has changed.

11. Based on the discussion we've had and your experiences with discharges at Harlem House, are there any ways in which you would like to see the discharge process improved or changed that you haven't mentioned?

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INTERVIEW GUIDE #2 - Staff Interviews on Continued Stays

Preamble:

The purpose of our meeting today is to talk about the clients at Harlem House who have stayed at the residence for a long time. As you know, some clients come and go quickly, while others seem to become more or less permanent residents. Our discussion will focus on clients who have been at the residence for more than 30 months.

In a way this is a special group of clients, since they are with us for so long. In discussing the long-stay clients with you, I'm hoping to gain your insights and ideas about why these clients have stayed with us for so long, while others haven't. I'm going to interview the whole staff about this and I'll share the results with you. When you and I talked about discharges from Harlem House at our last meeting, I told you that I wasn't evaluating your or anyone else's job performance. The same is true today. There are no right or wrong answers, I'm just interested in your ideas. Everything you say is totally confidential.

Questions:

1. Let's start by talking about "client Y" who has been at the residence since it opened in 1990. What kind of person is "client Y"? Let's talk about his/her time in the residence. Probes: a) relationships with staff; b) other clients; c) use of program at the residence; d) at Portals.

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2. Besides "client Y's" personality and behavior and his/her relationships with staff, are there any other factors you think might have contributed to "client Y" becoming "long-stay"?

3. Has your opinion of "client Y" changed since you first met him/her? If so what was it originally and how and why has it changed?

4. Why do you think "client Y" has stayed at the residence so long? Probes: a) client's role in assuming continued stay status; b) staff's role in conferring continued stay status.

5. Do you think that "client Y" should continue to live at Harlem House? Probe: if so, why; if not, why not?

6. Now that we've reviewed "client Y's" situation, let's talk about some other long-stay clients (repeat questions above for others on list).

7. Now that we've reviewed the long-term clients, is there anything else about them, the staff's relationship with them or anything noteworthy about their situation you would like to add? Probes: a) what do you think are the advantages of clients staying long-term at the residence; b) what do you think are the disadvantages or problems?

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INTERVIEW GUIDE #3 - Client Interviews on Continued Stays

Preamble:

I appreciate your meeting with me today. I'm talking with people at Harlem House who have lived in the residence for a long time. These interviews are part of research that I'm doing for school where I'm studying for a doctorate degree.

Since you've been living at Harlem House for a long time, I'm very interested in your experiences and your opinions about the program. There are no right or wrong answers to the questions we're going to discuss; just your opinions and experiences.

As you know, I have an important position over at Portals, but I'm not here today to evaluate you or the staff. Everything you tell me is strictly confidential and is for my school project only.

Do you have any questions at this point? If not, let's start.

Questions:

1. Can you tell me a little bit about where you were living before Harlem House and how you got to Harlem House? Probes: a) homelessness; b) prior living arrangements; c) relationships with family and others; d) previous experience in programs (long/short-term).

2. Tell me about your first visit to Harlem House. What did you think of the place? Probes: a) physical environment; b) clients; c) staff d) things they liked on first visit; things they didn't like.

3. At the time you moved into Harlem House did you have any goals? If yes, what were they? Probes: a) did they plan to stay indefinitely? for a time limited period?

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4. Tell me about your roommates and how you got along with them when you first moved in. Probes: a) have you had new roommates? b) how do you get along with roommates now? c) what about relationships with other clients in the residence, are any of them especially important to you in a good or bad way?

5. Let's talk about how you got along with staff when you first moved in. Probes: a) relationship with Residence Director, Assistant Residence Director, Senior Counselor, their assigned Counselor; b) was there anyone on the staff you had an especially good relationship with? c) was there anyone on staff you had a really bad relationship with? d) how are your relationships with staff now? (review list if appropriate).

6. What about your relationships with staff at Portals. Have any staff members there helped you work things out at the residence?

7. If you have a serious problem, who do you usually go to for help or advice? Probes: a) Harlem House staff? (who?) b)Harlem House client? Portals staff? Portals client? other? (who?).

8. Why have you stayed at Harlem House for so long? Probes: a) relationships with staff; b) relationships with clients; c) other factors.

9. What are some of the things you like best about Harlem House? What are some of the things you don't like?

10. What are your plans for the future?

11. Do you have any other thoughts or ideas about your stay at Harlem House and why you've stayed so long in the program?

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