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Rhetoric, reality and the vicissitudes of establishing relationships with people who are homeless and mentally ill

Blake-Steele, Wilmatine, D.S.W.

City University of New York, 1992

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Rhetoric, Reality and the Vicissitudes of Establishing Relationships with People Who Are Homeless and Mentally Ill

by

Wilmatine Blake-Steele

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.

1992

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.

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ABSTRACT

RHETORIC, REALITY AND THE VICISSITUDES OF ESTABLISHING RELATIONSHIPS WITH PEOPLE WHO ARE HOMELESS AND MENTALLY ILL

by
Wilmatine Blake-Steele

Advisor: Professor Mildred D. Mailick

This exploratory descriptive study addresses the issue of how to establish relationships with people who are homeless and mentally ill. Ten programs that provide services to homeless mentally ill people are included in this study. Workers and administrators are asked a schedule of questions to ascertain how they specifically establish relationships with homeless mentally ill people.

Some of the variables addressed are: the significance of worker knowledge, skill, education, ethnicity, steps and procedures. The above are explored with practitioners and administrators for each variables' significance in establishing a relationship with homeless mentally ill people.

Workers and administrators of ten kinds of programs, each targeted to provide services to different segments of the homeless mentally ill population, are interviewed. Information from participants is organized into recommendations for a workshop for students.

To Mama, Daddy, my husband, our son, and my sister, thank you for your support, love, patience and encouragement.

ACKNOWLEDGEMENTS

The words thank-you seem hardly sufficient to express my gratitude to those people who have assisted me in this process. Yet, there are many I would like to acknowledge by saying thank-you.

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Thanks to all of the program personnel involved in this project, particularly, Louis F. Cuocco, Bernie Wohl, Elie Valencia, Jacqueline Rivers, Kathy White, Murray Itzkowitz, Mark Vogel, Diane Sonde, and Tony Hannigan--administrators of the programs.

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INTRODUCTION

Statement of Unmet Need

Homeless people in America constitute one of the major social problems of the decade. Estimates of the number of homeless people range from 250,000 to 3 million (HUD, 1982; Hopper, 1984; Morse, 1986). The composition of homeless people has changed from a largely white, middle-aged, male population disengaged from family life to a diverse heterogenous group of people including women, children, adolescents, unemployed, elderly and mentally ill people. Estimates suggest that approximately one-third to one-half of homeless people manifest signs of mental illness. Psychosis, usually in the form of schizophrenia is the most prevalent mental illness. Estimates indicate 25-40% of homeless people suffer from schizophrenia (Morrissey and Levine, 1987).

In answer to the significant indication of mental illness among homeless people, advocates, service providers, psychiatric community members, media, and policy makers have addressed the need for services to mentally ill people (Bassuk, 1984; Levine & Stockdill, 1984). Service recommendations have ranged from outreach, outpatient care, day programs to residential care. In addition, the need for case management has been emphasized (Ridgway, Spaniol, Zipple, 1986).

Mentally ill homeless as well as domiciled mentally ill people respond to traditional mental health services with

varying degrees of engagement. Barriers to receiving service include lack of trust of service providers, previous negative experiences with the mental health care system and indigenous psychopathology (Segal, Baumohl, 1980).

Therefore, innovative approaches on how to assist homeless mentally ill people to receive needed services have been and are continuing to be developed. Involved in all of the efforts is the issue of the development of a personalized relationship, on the assumption that in order to be effective, a relationship must be developed with the client prior to the provision of services. How do workers establish relationships with people who are homeless and mentally ill?

Many in this client group respond poorly to the following: structured intakes/evaluations, day care programs, medication management, individual, group/family therapy, seeking out assistance on their own (Lamb, 1984). These responses are amplified with homeless mentally ill people more than domiciled mentally ill people as the latter group usually have more familial and/or community support to assist in compliance with the outlined tasks.

Homeless mentally ill people do not keep outpatient appointments, usually discontinue using medication shortly after being discharged from facilities (in patient or out patient) and usually have difficulty responding to the structure of traditional outpatient/day programs.

This study focuses on bridging the gap in the literature about how (specifically) homeless mentally ill people are

connected to services. It is the researcher's contention that the relationship with a worker provides the conduit for service provision, and in some instances is the service.

Given this assumption, how do workers establish relationships with homeless mentally ill people? There seems to be an elusive quality to establishing relationships with homeless mentally ill people. How is it done? This study will find out from workers what they do, and how they establish relationships with homeless mentally ill people, such that recommendations for a workshop can be available for training others for work with homeless mentally ill people. Perhaps parallels can be drawn and used for other clients with similar concerns all in an effort to connect homeless mentally ill people to services, to decrease the mental hospital in the streets.

This exploratory descriptive study is designed to add to the literature by describing how service providers undertake to establish relationships with homeless mentally ill people. Questions to be addressed are:

1. Are specific skills and/or training needed for service providers to establish relationships with people who are homeless and have mental illness?
2. Are there specific steps/procedures that a worker needs to follow when attempting to establish a relationship with a mentally ill person? If yes, what are they?

3. Do workers feel any process or procedure will guarantee or assure the establishment of a relationship with a mentally ill homeless person?
4. In what way does the race of the worker affect how relationships are established with homeless mentally ill clients? Can potential clients be engaged sooner, develop trust sooner if the client's and worker's race are the same? Is race a factor at all in establishing a relationship with a mentally ill homeless person?
5. Are educational credentials/skills helpful in this process? What criteria enhance establishing relationships with homeless mentally ill people?
6. Given the limited (services) resources available to homeless mentally ill people is there a process that workers follow in establishing relationships?
7. Do they find that within the process of establishing a relationship they know who will benefit most from services or who will not?
8. Are these issues addressed within the relationship process?
9. If workers can be taught how to establish relationships with homeless mentally ill people are there implications for other difficult to engage populations?
10. Do workers think training is needed on how to establish relationships with mentally ill people?
11. Do workers think credentials assist in establishing relationships with homeless mentally ill people?

Current Efforts

Mentally ill homeless people are among the more visible and needy segments of homeless people. The latest practice techniques relating the homeless mentally ill to the provision of a range of services and location of appropriate housing involve three areas: outreach, assessment and case management.

Therefore, innovative approaches on how to assist homeless mentally ill people receiving needed services have been and are continuing to be modified. Involved with all of the technologies/approaches is the issue of the relationship. A relationship must be developed prior to the provision of services. The establishment of a relationship is crucial between client/potential client and worker. For without the relationship

> ...it is impossible for case managers to perform any of their concrete tasks, such as assessment, reliably unless they have some sort of relationship with the patient (Harris & Bergman, 1986, p. 6).

How do workers establish relationships with people who are homeless and mentally ill?

The literature on homeless mentally ill people does not describe approaches to establishing relationships (engaging) this group of people. Nonetheless, the programs that are successful in establishing relationships have workers with knowledge and could assist others who may be reluctant because of difficulty of conceptualizing what they do. This study is

designed to ascertain such information then formulate recommendations for a training workshop for practitioners.

For the purpose of this study a mentally ill person will be defined as anyone who has a diagnosis from the DSM III R or DSM III given by a licensed clinician. Social functioning will be defined as anyone who is able to carry out the duties in society of working, socializing, handling daily activities of living, providing food, shelter, clothing, and handling monetary concerns.

If we looked at outreach and case management on a continuum, outreach would most likely be toward the left of the continuum representing the beginning stages of engagement in a relationship while case management would be located toward the middle location, procurement of services and housing would be one product of case management. The outcome, the person's ability to function as independently as possible would be on the right (social functioning). (See Table 1 below.)

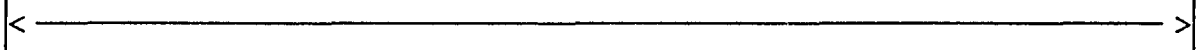
The issue which is not often discussed in the literature on homeless mentally ill people (unmet need) is specifically, how do you establish a relationship with a homeless mentally ill person?

The focus of this exploratory descriptive study is to address the question of how specifically relationships with homeless mentally ill people are established. For the purpose of addressing this question, the literature review is focussed

Table 1

CONTINUUM OF SERVICES

Outreach	Engagement	Assessment	Case Management	Social Functioning



Establishment and Development of Relationship

on five areas in an attempt to set some parameters around the question.

The sections begin with the more general, then move to specifics, (inductive): 1) homelessness (overview); 2) mentally ill homeless people; 3) outreach, case management; 4) establishment of relationships in social work.

Assumptions

Two assumptions are reflected in this study. The first is that there are steps in establishing a relationship with a person who is homeless and mentally ill. The steps do not always have an order. However, there are five components that are usually helpful in attempting to establish a relationship with a mentally ill homeless person.

The steps are as follows: (a) observation (by worker) to see where the person stays most of the time and what he/she does, attempting to isolate what the person likes, which can be used later in conversation and with the assessment; (b) assessment (including some knowledge of clinical theory so that one can understand and articulate what is being seen)

about strengths; (c) provision of concrete service--often coffee, food, money, what the person requests, within reason; (d) consistency, being in the same place (if applicable), treat/approach the person the same way each time; (e) persistence without being a nuisance, let the client control the time frame or the distance he/she wants between you and him/her.

2) In establishing a relationship with a person who is homeless and mentally ill workers operate on two tracks 1) they must attend to the motivational needs as outlined by Maslow to be discussed below, then 2) try to simulate a healthy mothering relationship of self and object.

Theoretical Underpinning

One theoretical underpinning can be found in Vigilante and Mailick's (1988) work on the importance of needs and resources in teaching assessment.

Organization

This section will be organized under four subsections: a) what the theory says, b) how this theory differs from others, c) how it will be utilized in this project, d) its applicability to establishing relationships.

What Theory Says

Vigilante and Mailick present a graphic method of teaching assessment in the social work curriculum through the use of a developmental wheel. They articulate areas and issues that should be addressed while making an assessment of a client. In addition, they see assessment as a dynamic

process that is on-going. Assessment relates to the service delivery for the person(s). The framework of assessment brings together needs of the individual and individual family and community resources. This graphic framework for teaching aspects of assessment allows that one can select from among issues as they become more dominant or diminished. It has combined a range of psychological and social theory necessary and relevant to the assessment process.

Developmental Wheel

The developmental assessment wheel will be briefly explained below because of its particular emphasis for this project. There are four major sections of the wheel corresponding to a four-step assessment process. The outer rim of the wheel describes, 1) basic human aspirations of all people, 2) the 'hub' (core-bottom center of wheel) describes the developmental needs of different periods in our lives, 3) the social pathologies (above developmental needs) articulate the negative societal conditions affecting everyone, directly or indirectly, 4) a series of individualized variables that affect each of us differently. (See figure A.)

The four parts of the wheel correspond with the four-step assessment process in:

1) identifying the person-institution;
2) considering the effects of social pathologies;
3) deciding on the relevance of the items in the spokes of the wheel; and,

4) determining the relationships of all the pertinent items to each other (Vigilante & Mailick, 1988).

How Theory Differs

The issues that make this theory different from others are: 1) it addresses and articulates the social pathologies clearly, while reminding the worker to look at their relevance to the assessment process, 2) this theory shows the interplay between the person's needs, available resources and possible barriers to accessing resources, internal and external. This approach moves away from blaming the victim to understanding and attempting to assist people in mobilization and advocacy.

How Theory Applies to Establishing Relationships

Although Vigilante and Mailick (1988) do not discuss establishing relationships specifically, the assumption is made that inherent in the assessment process a relationship must be formed to obtain the needed information about client need and available resources.

How Theory Is Utilized for This Project

This is an exploratory/descriptive study whose overall goal is to find out how workers establish relationships with homeless mentally ill people. Assessments are one of the ongoing processes that may or may not affect the relationship process. The researcher is interested in how workers address the need/resource issue. (Questions 17 and 18, administrator questionnaire.) In addition this is a theory for curriculum

development which is the product of this project, (congruence between project, theory, product).

Thus the theoretical underpinning for this project will be Vigilante and Mailick; Truax and Carkhuff; Maslow; Hollis; and Mahler.

Maslow (1954) says that there is a hierarchy of needs that all human beings aspire to. Frustration of these needs can lead to emotional problems, whereas gratification of the needs enables one to continue up the hierarchy of self fulfillment and motivation, and accomplishment.

Relationship

There are approximately eleven approaches/methods of delivering social work services to clients. (See Table 2.) The researcher concurs with Hollis in that relevant to all of the approaches is the relationship between client and worker (Hollis & Woods, 1981). The psychosocial approach informs this assumption and project as this approach spells out how/gives general guidelines on how to establish relationships. Other approaches seem to build from/use the psychosocial approach as a base of departure. Just as there can be little doubt that group work is a preferred methodology for reaching larger numbers of clients, the psycho-social approach is the oldest approach in work with individuals, and has utility in understanding and reaching out to them.

> Basic to psychosocial casework treatment, and one of its most powerful tools is the relationship between worker and client (Hollis & Woods, 1981, p. 284).

Table 2

MASLOW'S THEORY AND RELATIONSHIP PARALLEL

Maslow	Parallel Stages in Relationship
aesthetic	Workers taking clients to theater, movies, outings
self actualization	Workers find out through observation and conversation what person aspires to do and assists within reason
esteem	Worker and person jointly explore what can be done to make him/her feel better about him/herself
safety	Location of safe place to sleep at night; to rest
physiological	Assure person has food, clothing, shelter.

Hollis and Wood concur with Truax and Carkhuff, 1972 (to be discussed below) in identifying the aspects of a positive therapeutic relationship as warmth, genuineness, empathy and non-judgmental acceptance. In addition, the worker's optimism, objectivity, professional competence and capacity to communicate are important to the relationship (Truax & Carkhuff, 1972).

Definition of Relationship

For the purpose of this project, relationship will be defined as a process between worker and client/potential client that involves communication, attitudes, mutual effort (Vigilante & Mailick, 1988). It is a part of the vehicle for client change. Other variables enter into the change process, such as need and resources (Vigilante & Mailick, 1988).

The previous section was a statement of unmet need. This section addresses some of the parameters of the problem to be addressed.

POLITICS, POLICY, PEOPLE

The Reagan Years

Deinstitutionalization and current psychiatric hospitalization laws have influenced the current homeless population. In addition, the context of the current increase in homeless people is better understood in the light of former President Ronald Reagan's policy during his 8 year tenure. Specifically:

Table 3
APPROACHES IN CLINICAL SOCIAL WORK

THEMES	DIAGNOSTIC/ PSYCHOSOCIAL	FUNCTIONAL	PROBLEM SOLVING	CRISIS INTERVENTION	PLANNED SHORT TERM	TASK CENTERED	COGNITIVE BEHAVIORAL
Historical context	Influenced by Freud, Hartman, Rank, Richmond, Adams	Influenced by Taft, Rank, Alternative to Diag. Model	Perlman, Helen	1950s; result of post traumatic stress disorder of soldiers WWII	From problem solving, Perlman	Perlman, Schyne & Epstein	Skinner, Watson
View of the individual	Individual can function better, cope in environment	Individual can change	Mechanistic, individual continuously involved in solving problems; maintaining homeostasis	Same as problem solving	Same as problem solving	Some cognitive ability required	Individual capable of changing behavior
Underlying Values	Not selfish, racist, ageist, classist	Same as psychosocial	Person dealing with problem	Crisis has definite time span, 1-6 weeks			Problems are learned, can be unlearned
Goals	Adaptation/ maintenance	Change	To solve the problem	Focus on crisis resolution	Focus on problem for limited number of sessions	Focus on task, mutually defined by worker and client	Focus on changing behavior
Practice Assumptions	Environmental Context and intrapsychic components important	Importance of Agency Function	Awareness of conscious and unconscious processes, focus on conscious	Once crisis defined person can work through it	Same as crisis		Measurable results can be achieved
Nature of the Relationship	Relationship between worker and client important in addressing client problem	Relationship important, worker as representative of agency. Agency purpose does not change to suit client	Relationship important, worker and client important process of solving client problem	Helping person intervening in system; relationship important in process	Relationship important in problem solving process	Client as important as worker	Hierarchical, however client participates in defining behavior to be changed
Assessment Process	Focus on nature of problem	Focus on how agency function can/ cannot address problem	Focus on problem to be solved	Focus on problem and learning process of how to handle next crisis	Length of time crucial to addressing problem	Focus on task, other issues referred elsewhere	Focus on present situation, current issues
Process of Change	Focus on helping person function in his/her environment	Person can change	Focus on present, current parameters of problem, person can work through problem	Person can get through crisis		Person can solve problem	Focus on helping individual change behavior
Target Population	Individual, group, family	Individual, group, family	Individual, family, group	Individual group, family	Same	Same	Same

- The federal government made the decision to move out of the public housing business.
- There was a change in policy affecting those seeking Social Security disability payments which made it more difficult to obtain benefits for some and discontinued benefits of many already receiving income.
- There was no increase in public assistance benefits to keep in step with inflation over the last decade.
- There were decreases in Aid to Families with Dependent Children (AFDC). Since 1981 there has been a $3.6 billion cut in AFDC funds (National Coalition for the Homeless, 1986, p. 3).
- There were tax incentives, benefits for wealthy Americans and poor people continued to get poorer.
- During the first four years of office the Reagan Administration made the following budget cuts affecting poor families and children;
  - housing assistance 1.8 billion
  - AFDC 4.8 billion
  - child nutrition 5.2 billion
  - HUD's (Housing and Urban Development's) budget to help low income families cut from 30 to 11 billion (Palmer, 1986).

In 1981 the Social Security Administration undertook an investigation of the records of those who were receiving disability benefits. By 1985, 491,300 had been dropped from the roles (National Coalition for the Homeless, p. 3).

The Reagan administration focused on a social agenda: anti-abortion, opposition to school busing, in favor of school prayer, and tuition tax credit for private schools. The administration stressed local over federal control. Given this context, the Reagan Administration met any reports about homelessness spreading with counter charges of exaggeration, hence dismissal of the problem. Reagan's program emphasized: 1) negative government, 2) supply side economics, 3) a social agenda.

Homelessness has always been a part of the American tapestry, at different times dependent upon poverty, policy, and society. If we were to construct a time line of homelessness in America it might look like the one below: (Table 4)

The current influx in homeless people in America seems to be related to:

- poverty
- Reagan policy
- decrease in low income housing
- deinstitutionalization and current psychiatric hospitalization policy
- paucity of low cost housing

With the election in 1980 of Ronald Reagan as President of the United States of America, the nation embarked on a departure from its previous federal policy position with regard to life of the people. Since President Franklin D.

Roosevelt and the New Deal, the politics of America have been characterized by the federal government's involvement in social affairs and economic issues (Palmer, 1986). President Reagan challenged the role of the federal government's public responsibility for private welfare of the individual (Palmer, 1986).

Table 4 outlines an abbreviated history of homelessness in America, despite the appearance at times that homelessness just occurred in the 80's.

Mental Health Policy

Complicating and contributing to the number of homeless people are those who are mentally ill who were previously hospitalized or never hospitalized. The current mental health hospitalization policy requires that individuals must be of danger to themselves or others in order to be hospitalized (psychiatric). One translation -- a person has to have harmed someone else or himself to be hospitalized. Controversy exists within the psychiatric community about this policy, and there is in addition, a political debate between the legal community (American Civil Liberties Union) and the psychiatric community. Both flex muscles to show their power and control over the homeless mentally ill. For example, a woman in New York City, "Billy Boggs" (also known as Joyce Brown, (The New York Times, January 18, 1988, p. B3), lived in front of an apartment building for months on Manhattan's East side, refusing help from family, mental health or social service

systems. Once hospitalized for psychiatric observation, the American Civil Liberties Union defended her right to live on the street and challenged her being forced to take medication against her will. Billy Boggs, an assumed name, was discharged from a city hospital. At one point she lectured with her ACLU lawyer about her experiences. Ms. Boggs also cited the reason for her not wanting to take medication was due to a past history of substance use. Since she stopped using substances, she did not want to take any mind altering drugs (The New York Times, January 1988, p. B3). She did not take medication in the hospital, and was subsequently released.

Table 4

ABBREVIATED HISTORY OF HOMELESSNESS IN AMERICA

1600s	Towns in colonies took care of poor under Elizabethan poor laws; made distinction between those with skills/means and those without; transient poor moved from community to community
1700s	Almshouses
1800s	Civil war; increase in homelessness and transients after war; railroad construction, their maintenance, commercial agriculture created a society need for transient people; police departments used for lodging and municipal lodging houses
1900s	Shanty towns; Skid rows
1930s	The Depression - increase in homelessness
1940s	Technological advances made less need for transients; Skid rows becoming smaller
1950s	War over, employment high; skid rows and homelessness declined;
1960s	Renovation of major urban areas
1970s	Decreased need for single room occupancy hotels for elderly due to Social Security old age benefits; homeless now including more families in SROs; more people with emotional illness seen on the streets
1980s	Need for municipal, private shelters in most urban areas throughout US, particularly urban areas.
1990s	Debate on not enough information about homeless people vs. increasing population of homeless men, women, children. Attempt made to count homeless people by U.S. census

Chapter 2

LITERATURE REVIEW

Homelessness

While homelessness is one of the major social problems of the decade (Baxter & Hopper, 1981) it is not a new phenomenon in America. Almshouses and work houses were established during the colonial period for people who had no homes. There were hoboes and vagabonds of the 1930s as a result of the depression, and many urban cities had skid rows (Goldfinger, 1984). Historically, homelessness could be viewed as a reflection of the interaction between the most vulnerable in our population and the diminishing of resources (Lamb, 1984). All of the homeless population are not mentally ill, although there are a sizeable number who do have emotional problems. The exact number of mentally ill people within the homeless population is unknown (Levine, 1984).

Causes and Definition

"Until the 1970s, a homeless person was generally viewed as a white male alcoholic who had broken all ties with his family and refused help from social agencies. He lived in a distinctive area known as skid row" (Hopper, 1983, p. 30). The definition of a homeless person has changed. Homeless people in the 1980s are: men, women, children, youth, mentally ill, substance abusers (Encyclopedia of Social Work, p. 638). The definition of homeless for this study is any individual or family that does not have permanent housing.

Therefore, people living in shelters will be considered homeless as well as people living in the streets, cars, abandoned buildings; doubled-tripled up with friends, acquaintances/family.

The causes of homelessness are complex and the population is heterogenous (Goldfinger & Allen, 1983; Hopper, 1983, Baxter & Hopper 1981). There are subgroups among the homeless people with different needs; some of the needs parallel the reasons which contributed to their homelessness. Some have lost their employment, others are homeless because of gentrification of urban areas with lack of replacement housing, still others suffer from chronic substance abuse and/or mental illness (Levine, Lezak, Goldman, 1986).

Smith (1988) points to the fact that the number of homeless people is growing particularly homeless families with children. Homelessness is not abating.

> Although the Reagan administration denies responsibility for the trend, many mayors and state officials put the blame squarely there. What's happening now, they say, is the result of years of cutbacks in public housing and other federal social programs, including job training, food stamps, health care and spending on the mentally ill (Smith, 1988, p. 24).

As a result of these cutbacks the homeless population is now increased by low income families, displaced by urban renewal or rent increases; many work and not all are on public assistance (Smith, 1988). Many of today's homeless are minority children.

In a "New Look at the Homeless," Rivlin (1986) reminds us that: Homelessness is not a new problem. America had homeless people whom it called "paupers." This group of people included: sick, aged, and indigent. Seen from some distance the policies that we have today seem to reflect the same way we dealt with paupers in Colonial times.

Exact numbers of homeless people are not possible to calculate since being homeless makes it difficult for people to be counted, unless they come in contact with an official agency. Government policy today is based on emergency need (residual policy). Rivlin suggests we can do something about homelessness on a personal, political, and programmatic level; that we help homeless people feel less alienated from society; address their needs by eliminating poverty.

Homeless

Frazier (1985) points to the fact that our country was founded by homeless people. He suggests that we separate the homeless population into two parts, the homeless and the mentally ill homeless. In responding to the needs of the homeless mentally ill, he asks us to think about homelessness and the mentally ill homeless as two issues; homelessness as a social issue and the mental ill as a clinical issue (Frazier, 1985). Frazier states that sometimes these issues are distinct and at other times they are critically intertwined. Factors that contribute to homelessness also affect the mentally ill homeless person: economic

deprivations, paucity of low-cost housing, discontinuance of social services, changes in American families (Encyclopedia of Social Work, 1987). In turn, the symptoms of mental illness interfere and prevent the mentally ill person from coping with the stressors mentioned.

Demographics

The homeless population is a heterogenous group; however, they have one common need -- affordable, safe, permanent housing. Some subgroups need additional services. The mentally ill homeless subgroup is among them (Lamb, 1984).

With the exception of war or natural disasters, there is no uniform cause that leads to someone being homeless, although there is a consensus about the general pool of events responsible for homelessness in America: 1) the recession - "unemployment reached a peak of 10.7 percent in November 1982, the highest level since the Great Depression" (Encyclopedia of Social Work, 1987, p. 790). 2) a decrease of low-cost housing stock, 3) changes in policy regarding the mentally ill, and 4) the deliberate attempt by the federal government to decrease the number of people receiving Social Security Disability Insurance (Encyclopedia of Social Work, 1987). Cuts in federal programs, social security insurance and public assistance have exacerbated the poor implementation of deinstitutionalization. In 1991, unemployment was 8.3% (total for all of United States). 20.1% of the above percentage were African Americans. Of the 8.3% total Americans who were

unemployed, this represents 6.6% of the total labor force. For African Americans the 6.6% almost doubles, becoming 12% unemployed for African Americans.

The above data was provided by Max Stamper, National Urban League, New York, New York.

Mental Illness

Mental illness has been with societies for as long as historians and philosophers have written about them (Bokhoven, 1972). Looking at the issue of how the mentally ill in the U.S. have been treated, Bokhoven suggests:

> Society's reaction to the mentally ill has oscillated throughout recorded history between brutality and benevolence (Bokhoven, 1972, p. 10).

If we would construct an abbreviated time chart line of how mentally ill people were treated in America since the establishment of the colonies, it might look like Table 5, listed below. Material for the abbreviated time line is drawn from Bokhoven (1972) and Torrey (1988).

Mentally Ill Homeless

For some mentally ill homeless people the nature of their symptomatology contributed to their homelessness; for others, economics and the design of the mental health system did; yet other homeless mentally ill people are affected by the lack of inexpensive housing. "Between 1970 and 1980 nearly half the single room rental units in this country were converted or destroyed" (Frazier, 1986, p. 463). Frazier

Table 5

ABBREVIATED HOMELESS MENTAL ILLNESS HISTORY CHART

This chart presents an abbreviated history of homelessness in America from 1600 to present (Bokhoven, 1972; Torrey, 1988; Tratner, 1984).

1600s	Vagrants, run out of town
1700s	Alms houses, mentally ill treated inhumanely and as oddities; exhibited
1800s	Humanistic Science Moral Treatment The patient's comfort, interest was stressed, then discussion of concerns elicited (Bokhoven, 1971)
1841	Dorothea Dix-goal; all mentally ill placed in mental hospitals instead of alms houses or jails
1870s	Breakdown of moral treatment
1900s	Institutions, belief mental illness is curable
1950s	Population of state hospitals highest ever - 500,000 patients, Psychotropic medication
1960s	Deinstitutionalization
1970s	Asylums in the street, psychiatric hospitalization policy more rigid
1980s	Beginning of discomfort with hospitals in the street
1990s	Same as above

(1986) says that public policy is not synchronized with the needs of the growing population of mentally ill homeless, and at times the group and the policies are moving in opposite directions. An example of this is, as the debate continues about who and how many mentally ill homeless people there are, mentally ill patients are continually discharged from hospitals to the community with little or no follow-up.

Frazier (1985) also points out that many of the homeless mentally ill suffer from schizophrenia - a disease which attacks our youth and for which the psychiatric profession has no cure. He alludes to the need to spend more time and energy in understanding the disorder of schizophrenia.

Bachrach (1984) points to the interaction between deinstitutionalization and demography in contributing to the homeless mentally ill population. The 64 million babies born between 1946 and 1961 have come of age, increasing the number of young people at risk of developing schizophrenia. In addition, as a result of more flexible transportation and mobility among young people, we have a more visible mentally ill population (Bachrach, 1984).

As the homeless population grows so too does the mentally ill homeless population. For the same legal system that promoted a policy of deinstitutionalization is still in effect, and people are still being released from hospitals with no place to go except a shelter (Gralnick, 1984). Add to this the fact that there is still no cure for the most debilitating psychiatric

disorder, schizophrenia, (Goldfinger, 1983) and society has a recalcitrant problem.

Frazier (1985) also suggests no fast solutions despite the difficulty in seeing people grouped in the streets and rummaging through garbage for a meal. He suggests changes throughout the entire system which are patient oriented (Frazier, 1985). The mentally ill homeless are people whose current homelessness is indicative of their complicated psychopathology or is the cause of their homelessness (Goldfinger, 1986).

In Treating the Homeless: Urban Psychiatry's Challenge a compilation of six studies, Jones (1986) addresses the difficulty in the provision of treatment and services to homeless mentally ill people. Each of the studies reports on research conducted in shelters or the streets. Findings from these studies are:

1. Concurrence with the range of estimated homeless people from 250,000 (HUD) to 3 million (Hombs and Synder 1982, p. 110).

2. The homeless population is changing. The average age of a homeless person is late twenties to mid-thirties. There are an increasing number of women, children, adolescents, families, and minorities.

3. The percentage of mentally ill people among the homeless declined from 60-80% in 1980 to 25-35% in 1985 as other groups entered the groups of homeless.

4. Drug abuse (25-35%) and alcoholism (30-40%) affect many.

5. Transient homeless has increased.

6. The chronically mentally ill among the homeless have episodic decompensation; as well as poor to no social support network (Hombs, 1982).

In their descriptive study, Bean et al. (1987) interviewed 979 homeless people in Ohio finding that slightly under one-third of the people in the study demonstrated the need for psychiatric services. In terms of findings, they suggest that clinicians and epidemiologists gain trust and then try to provide services to homeless mentally ill people.

The homeless mentally ill pose different kinds of problems necessitating a range of services. Some of the needs include food, shelter, clothing, opportunities for positive social interchange, mental health services, rehabilitation, income support, health care, and permanent housing with supportive services (Lovell, Barrow, Struening, 1984).

In reestablishing homeless mentally ill people to the community, outreach is viewed as necessary and crucial (Axelroad & Toff, 1987).

Homeless mentally ill people may reject assistance from mental health workers because of previous negative experiences. For this reason, provision of services by outreach workers requires much time and energy to be successful in assisting the mentally ill homeless person to accept needed services. The tasks of the outreach worker is thus to link the homeless mentally ill person with services.

In the first of four knowledge development meetings sponsored by the Clearinghouse on Homelessness Among Mentally Ill

People, (Champ, March 1987) the practice of outreach as a viable means of connecting the mentally ill homeless population to services was viewed as a necessary tool in reaching homeless people.

Goldfinger (1986) in "Treating a Homeless Mentally Ill Patient Who Cannot Be Managed in the Shelter System" suggests a support system be constructed that will assist the homeless mentally ill. This support system will help fill the gap created by the paucity of services for this group and help alleviate the problem of agencies and programs that only provide assistance with a part of what someone might need: thus leaving them to negotiate a bureaucratic system which they are unable to manage for the remainder of the service. "No agency views itself as responsible for services outside its specialized domain" (Goldfinger, 1986, p. 577). Goldfinger also concurs with an APA Task Force recommendation that "a system of responsibility for the mentally ill living in the community ...with the goal of ensuring that ultimately each patient has one person responsible for his or her care (case manager)" (Goldfinger, 1986, p. 578). The American Psychiatric Association (APA) task force was formed in 1983, Dr. Richard Lamb, chairperson. The goal of the task force was to gather information, document the unmet needs and make policy recommendations.

Deinstitutionalization

The policy of deinstitutionalization was to decrease the length and frequency of stay of an individual in an institution. Deinstitutionalization came about as a result of a number of

factors: 1) "negative effects of institutionalization documented by journalists and social scientists"; 2) the high cost of institutionalization versus the proposed alternatives of community based care; 3) advances in medical (neuroleptic medication), social and psychological services; 4) the civil rights movement with its emphasis on the protection of the rights of individuals' due process rights," (Encyclopedia of Social Work, 1987, p. 376) along with approaching treatment in the less restrictive manner; 5) the development of a public aid system that allowed the private sector to provide services and a system that allowed "in kind room and board" (Encyclopedia of Social Work, 1987, p. 376) to be replaced by cash grants made directly to the client.

The first goal of deinstitutionalization was accomplished--the length and frequency of stay in institutions was decreased, but the second as promised by the 1963 Community Mental Health Act has not been achieved. The federal assistance needed to build and operate community mental health centers was insufficient. One solution that has been offered to resolve the problems of chronically mentally ill homeless is to put into effect the plans of the 1963 Community Mental Health Center Act by providing for their diversified housing options and health service needs (Encyclopedia of Social Work, 1987, p. 376).

Bassuk (1984) also cautions us that we have to be aware of psychiatry's limitations. There are some people who might not be able to be rehabilitated. These people need safe and humane care.

In his article, "The Case Against Deinstitutionalization," Gralnick writes:

> Deinstitutionalization is more than a policy: it is a social movement that appeals to both ideals and ambitions. Promising both economic savings and greater respect for the rights of patients, it easily gained political and psychiatric support,...we are probably not saving money, and even if we were the price in suffering and lost opportunity would be too high (Gralnick, 1987, p. 4).

Deinstitutionalization was not a bad idea (Lamb, 1984), but retrospectively the manner in which it was implemented clearly was problematic for a large portion of people (Hopper, 1983), those on the streets who are unable to care for themselves and look as if they would not be able to function outside of a hospital setting (Levine, 1984).

Also, in retrospect, nursing homes, welfare hotels, prisons, were not appropriate replacements for state mental hospitals (Morrissey, 1987). Some of the people discharged from institutions as a result of deinstitutionalization or those never hospitalized as a result of deinstitutionalization policy were too ill or too unqualified socially to survive in any setting other than a hospital (Lipton, et al., 1983). This group of people are now in the streets (Morrissey, 1987).

Lipton and Sabatini state that:

> We should not deceive ourselves that we have deinstitutionalized these patients; rather we have created a new institution - an asylum without walls in which the homeless psychiatric patient is disgracefully abandoned to meander like a vagabond (Lipton et al., 1983, p. 821).

The previous section concerned policy issues. The next section will address intervention.

Outreach

Axelroad and Toff say that outreach is difficult to define as it often overlaps with and/or includes the definition of case management and crisis intervention. They define outreach as "...a service that increases the access of a homeless mentally ill individual to other needed treatments and services" (Axelroad & Toff, 1987, p. 3).

Morse (1986) points to people who are homeless and mentally ill, living "... in abject poverty experiencing a quality of life that is significantly poorer than that of non-homeless mentally ill persons or the general population" (Morse, 1988b, p. 1). He suggests that the dimensions of outreach may vary according to the program, but that outreach program dimensions include:

1. The location of the outreach (mobile/fixed) site. A staff providing mobile outreach that will locate homeless people in different settings such as shelters or street locations. A fixed site outreach providing day programs or drop-in centers.

2. Type of interventions; how much social organization is involved in the intervention. For example, does the program include education, training, consultation?

3. Staffing patterns for outreach programs vary from non-professional consumers to doctorate level specialists.

4. Types of services provided by outreach programs might include: crisis intervention, assessment, case management, referrals, advocacy, community organizing and counseling.

Morse (1986) considers engagement an essential component of outreach. Morse also outlines the special features of outreach

to the homeless mentally ill including providing of engagement services for people who are wary or suspicious of receiving help (Morse, 1986).

Engagement

Rog (1987) discusses engagement as "an approach" to working with different groups of people including those who are homeless and mentally ill. She states that the engagement process includes: 1) an unobtrusive offer for assistance with basic services, 2) clear limited goals, 3) a non-threatening manner, 4) an individualized approach requiring flexibility, 5) accessibility to service for those who are motivated and unmotivated.

Some of the qualities necessary for engagement she discusses are:

1) Personal Qualities (of worker)
    a) patient and persistent
    b) need for realistic expectations
    c) non-judgmental attitude
    d) reliability, dependability, flexibility
2) Professional Qualities
    a) training in clinical skills, knowledge of mental health pathology and clinical supervision
    b) ability to assess the individual's need
    c) ability to connect the individual with services
3) Service Setting Qualities
    a) non-threatening
    b) an environment which is similar to home (Rog, 1987).

Cohen et al. (1984) describe Project Help in New York City, a mobile van team which has the legal power to evaluate and transport homeless people who may be mentally ill to city hospitals for further evaluations or shelters. While the authors have noticed a growing trend toward reversing deinstitutionalization, they feel that this will not solve the problem of people who are homeless and mentally ill.

In her study of five community support systems (CSS) programs in New York City, Barrow (1988) refers to the process in which clients become involved with agencies, workers or receive services as engagement. She viewed engagement as the "trusting relationship between worker and client" (Barrow, 1988, p. 11) that serves as the forum for assessment, contracts and service delivery. Barrow (1988) also noted that program context affected how clients come and are connected to the program (Barrow, 1988).

In her study she found two aspects of the engagement process that differed in the five cities. These were: 1) the way clients were recruited and the amount of time before in depth services began. She noted that "variations in the intensity or frequency of a client's contact with a program may also have to do with differences in how the programs operate and what clients seek from them" (Barrow, 1988, p. 11).

Homeless mentally ill people frequently avoid contact with other people, particularly mental health professionals.

Engagement is crucial in working with homeless mentally ill people. It is the "process" of "mutual respect and trust in the helping relationship" (Barrow, 1988, p. 11).

Cohen (1989) suggests an empowerment approach of engagement which includes: 1) a clear offer of services, 2) provision of services in a flexible and voluntary way, 3) aiming services to meet clients' perceived needs, 4) mutual aid groups for building connections between clients; client empowerment is the foundation of these strategies (Cohen, 1989, p. 305-308).

Case Management

Case management is viewed by many authors in studies as essential to providing services to the homeless mentally ill. Case management is defined as:

> Activities aimed at linking the services system to a consumer and coordinating the various system components in order to achieve a successful outcome. The objective of case management is continuity of services...Case management is essentially a problem-solving function designed to ensure continuity of services and to overcome systems rigidity, fragmented services, misutilization of certain facilities and inaccessibility (Human Resource Development, p. 7).

The case manager must also be able to respect and identify strengths, all while being realistic about a client's limitations. Case management is viewed as having six functions: 1) client identification and outreach 2) individual assessment 3) service planning 4) linkage to other services 5) monitoring of service delivery; and 6) client advocacy (Ridgway, Spaniol, & Zipple, 1986).

There are several models of case management that are discussed in the literature: 1) Generalist model, one individual

is responsible for all case management services; 2) Specialist model, the client has one person (the case manager) responsible for only one aspect of the case management process, e.g., assisting with entitlements, locating appropriate housing); 3) Therapist-case manager model, clinicians, public and private, performing case management services; 4) Family model, families of the mentally ill persons functioning as case managers; 5) Psychosocial rehabilitation center model, agencies that have comprehensive services; 6) Supportive care model, citizens in the communities where the clients live provide case management service; 7) Volunteer case managers, agencies/programs who provide case management on a volunteer basis (Levine, et. al, 1986).

Services

Levine states that homeless mentally ill people are not served adequately by either the mental health or shelter systems, rendering them dually disenfranchised. Several suggestions are presented for the types of services that the population needs including: emergency shelters, drop-in centers, outreach programs, crisis intervention, transitional and long-term housing (Lamb, 1984). Levine suggests that at each stage of work with mentally ill homeless people their basic and specialized needs have to be met. She cites several service and outreach programs because of their organization's exemplary manner in which people were approached.

Adequate and appropriate services for mentally ill homeless people require a range of housing services connected to

supportive services that can address basic and specialized needs. Lamb suggests that the component of structure is often missing in the facilities that are already set up (Lamb, 1984; Hopper, 1983; Baxter and Hopper, 1981).

In her descriptive study, Bachrach examines the increasing problem of homeless mentally ill people; she concurs with other researchers that studying this group is difficult due to their mobility (Bachrach, 1984). The article concludes with nine planning principles for improving services to the mentally ill homeless population. Bachrach (1984) suggests: 1) precise goals and objectives need to be stated that are consistent with the resources for the target population; 2) in terms of setting priorities, those who serve the homeless mentally ill must be advocates for assisting the population in receiving services they need and in removing barriers to those services; 3) reassessment of institutional alternatives; 4) comprehensive services, and service systems that aid this population should be interrelated; 5) there needs to be interagency cooperation, communication and linkages between agencies; 6) individualized programming is essential; 7) flexible format; progress with this population is not necessarily linear, and programs must be flexible to accommodate the changing needs of the person; 8) cultural relevance is important in the design of programs; 9) caution and restraint should be exercised, so the worker is not seduced by the quick fix.

In "Managing Homeless in Transportation Facilities," Sullivan points out that no one knows the exact number of

homeless people, or how many homeless mentally ill people use transportation facilities for shelter (Sullivan, 1986). Sullivan states that homelessness, a major social problem, is also an increasing problem for urban transportation systems. In urban transportation (bus, train, subway) systems, we now have a large number of homeless mentally ill people who use these facilities as shelters. Since this is not what the transportation facilities were designed for--homeless mentally ill people using these facilities and the people who come to victimize them--problems are posed for the facilities and the passengers who use them. According to Sullivan, "what we have now are essentially psychiatric units without medical or support services or supervision in many of the nation's major transportation facilities" (Sullivan, 1986, p. 6).

Sullivan suggests that this aspect of the homeless problem should be approached through the use of outreach teams to facilitate getting homeless people the services they need. The outreach efforts need to be connected and coordinated with community medical and mental health services. Sullivan also concludes that "to effectively mitigate the inhumanity of homelessness a reassessment of deinstitutionalization and the role of the state hospital is now necessary" (Sullivan, 1986, p. 18).

Research Reports

Beginning in 1983, NIMH awarded grants to ten research groups to develop a database of demographics, service needs and mental status of homeless mentally ill people. Annual meetings

beginning in 1984 have been held where researchers presented their findings.

The National Institute of Mental Health (NIMH) published an administrative document summarizing its most recent research consisting of ten funded studies of the homeless mentally ill done in different parts of the country. The findings of the research were presented at the Third Annual Meeting of NIMH - Funded Researchers Studying Homeless Mentally Ill Persons, July 24-25, 1986 (NIMH, 1986).

The majority of the ten studies were descriptive and covered periods of one to two and a half years during the period from 1983 to 1986. None of the studies had a method of differentiating between persons who became homeless after mental illness and those who were homeless prior to mental illness.

The findings in this report represent only those that the researchers felt most important to a policy or practice perspective. There were four general findings reported by each study:

1. Homeless people in America are a heterogenous group of people with multiple service needs. Estimates of the percentage of mental illness within the homeless population vary depending on how the information was obtained. The percentages range from a low of 25% to a high of 50%. People with chronic mental illness were less able to locate and maintain employment; thus they generally have no income from employment. All ten studies found that the mentally ill homeless population had significant physical health problems, poor social relationships, high

substance use and abuse and dual diagnoses (NIMH, 1986). Homeless mentally ill persons tended to be long term residents of local areas in which they were studied. However, there were few residential options available to them in these areas. Population members also had definite preferences for the types of accommodations they wanted, not necessarily concurring with service providers. The most frequent disagreement came from homeless people wanting to return to the communities they were reared in, even when housing was unavailable.

2. A sizeable number of homeless mentally ill people had been involved with the police or had been in jail (Lamb, 1984). Crimes ranged from loitering to drug possession.

3. Although the homeless mentally ill people are willing to accept some offers of help, the providers' perceptions of needs/service priorities of homeless mentally ill people often do not coincide with the mentally ill people's perceptions. Lack of basic needs: food, clothing, housing, seem more relevant to the homeless population than mental health services.

Further implications from these studies are: a) homelessness is not a mental health problem, but multiple interventions are needed for remediation and intervention with people who are homeless and mentally ill; b) multifaceted housing on a continuum is needed, from long to short term housing (Bachrach, 1987); c) the criminal justice system has replaced the mental health system as primary provider of care for many mentally ill persons; d) "blaming the victim" responses and agencies are not effective.

The NIMH study concludes with the fact that there is still little evidence to indicate what is the most effective approach with each individual within this subgroup. With regard to the best program for homeless people, NIMH's position is that there is no right or wrong type of program to address the needs of the homeless mentally ill population as the issues are still too new and diverse.

Levine, et al. (1986) in their article "Community Support Systems for the Homeless Mentally Ill" suggest that the approach of Community Support Systems (CSS) units in a network throughout the country provide an appropriate way to serve homeless mentally ill people (Levine et al., 1986). This approach assumes that the population needs not only mental health treatment but also a range of social supports. Case management is also viewed as a vital part of the package for services for the mentally ill homeless.

Summary

Research about homeless people within the last ten years has contributed to answering some of the perplexing rudimentary questions. We now know who homeless people are: families, children, women, the elderly, the unemployed, alcohol and substance abusers, and overwhelmingly, poor people (Morrissey and Levine, 1987). Homeless people are predominantly, but not entirely, from minority groups (Lamb, 1984). In addition, we have some understanding about why the numbers change. Homeless people do not necessarily stay in one place/locality all the time. However, the inability to discern the precise number count

of homeless people is not considered as crucial as procedures to prevent homelessness or reverse its state once established (Gralnick, 1987).

Gralnick states, "We are regressing to the way the insane were treated in the days before state hospitals existed. Considering the hidden costs, we are probably not saving money and even if we were, the price in suffering and lost opportunity would be too high" (Gralnick, 1987, p. 52).

Mentally ill homeless people are of no particular age, sex, or ethnicity. The most prevalent mental disorder is schizophrenia, followed by affective disorders. Some of the people have been hospitalized and are the products of deinstitutionalization, while others have never been hospitalized and are products of the legal system's hospitalization laws that state patients must be a danger to themselves and others before being involuntarily hospitalized.

Outreach--going to where the homeless mentally ill are to offer services--seems the best and primary way to engage this population. Case management is most effective in provision of in-depth care that many homeless mentally ill people require. A continuum of services is still needed in large enough numbers to handle the growing population needs from outpatient, day care, residential, transitional to permanent housing. All people who are homeless and are mentally ill share the need for permanent housing.

The following two tables summarize the current state of the literature on homeless people with regard to the parameters of

this study in abbreviated chart format. Table 5 is a synopsis of studies utilized, Table 6 is a synthesis of current knowledge base.

Theoretical Underpinning

Establishing Relationships

Establishing a relationship with a homeless mentally ill person is pivotal in the provision of services to this subsection of the homeless population. There is literature on outreach, case management with homeless mentally ill people, however the specifics of how relationships are established have not been given detailed attention. Cohen (1989) outlined earlier an empowerment approach to engagement with homeless mentally ill people.

Relationship provides the conduit for the provision of services. Without it, the homeless mentally ill would continue not getting the assistance they need. Mahler, 1978, Horner, 1989, and Hedges, 1983 address issues of attachment and object relations--how people relate to others.

Aspects of object relations and ego psychology theories will be referred to in discussing techniques to establish relationships (engage) homeless people who are mentally ill.

Table 6

LITERATURE REVIEW TABLE

This chart presents the literature on homeless mentally ill people in abbreviated chart format.

Source	Program Description	Study Design	Findings/Conclusions
Axelroad, S. and Toff by CHAMP	1st of 4 fact finding meetings		outreach services are necessary to connecting mentally ill homeless people with appropriate services.
Bachrach, L.		Descriptive	9 principles for programs in work with homeless mentally ill.
Barrow, S.M.	5 CSS programs in NYC studied for 6 months, ascertaining how they engaged and provided direct services to homeless mentally ill clients	Descriptive/ Exploratory	engagement differed according to site; clients' and workers' priorities not necessarily synonymous; case management essential in assisting clients in maintaining service links.
Bassuk, E.L. Robin. L. Lauriat, A.	75 homeless men and women interviewed in an emergency shelter; large proportion in need of psychiatric services.	Descriptive	homelessness due to deinstitutionalization; shelters are mini institutions; homeless need decent housing.
Baxter, E. Hopper, K.	interviewed homeless people	Descriptive	homelessness caused by unemployment, lack of decent affordable housing, deinstitutionalization, heterogenous population.
Bean, Jr. Howe, S.	979 homeless people were interviewed in Ohio	Descriptive	slightly under one third of the sample found to need mental health services. In working with homeless mentally ill providers should proceed cautiously.

Source	Program Description	Study Design	Findings/Conclusions
Cohen, M.D. Marcos, L.	Description and discussion of ethical dilemmas with a program like Project Help	Descriptive	Project Help reflects a shift in how involuntary treatment of homeless mentally ill is handled.
Cohen, M.D. Neal, L. Putnam, J.F.	Project Help of NYC described mobile van with staff who have power to evaluate and remove homeless mentally ill from street	Descriptive	homeless mentally ill people adapt to cold weather; basic needs of clients need to be met first then rehabilitation.
Frances, A. Goldfinger, S.		Descriptive	a system of responsibility needed for mentally ill homeless; case management; frequent attempts may be necessary before the person accepts help.
Frazier, S.	Information/ historical prospective	Descriptive	homeless mentally ill serve as reminders of deinstitutionalization failures; homelessness is a social problem; mental illness a clinical problem.
Goldfinger, S. Allen			a system of responsibility is needed for mentally ill living in community; each person needs a case manager.
Hopper, K.		Descriptive	number of homeless people not defined; causes of homelessness: a) unemployment, b) scarcity of affordable housing, c) deinstitutionalization of mentally disabled, d) social service cutbacks. Homelessness - major social problem. Jobs needed for homeless who can work; housing.
Lamb, R.	Study focused on homeless people 18 yrs or older	Articles, books, compilation of previous studies	homelessness not new phenomenon, exact number unknown; deinstitutionalization not bad idea - implementation poor. Attempts to help homeless mentally ill must start with addressing their basic needs for food, clothing, shelter, adequate community housing, comprehensive accessible psychiatric and rehabilitative services, general

Source	Program Description	Study Design	Findings/Conclusions
			medical assessment and care; available crisis services; difficulty in working with population should not be overlooked; basic changes in legal system needed; system of coordination between funding sources that service group; more financial resources; some potentially ill homeless cannot be helped without a period of hospitalization; there is subgroup within this subgroup who are young, chronic urban nomads" more mobile than regular population; needs more informality, flexibility, less invasiveness services to the psychiatric homeless population, more complex 1. there is no "quick fix" for homeless mentally ill 2. retrospectively, deinstitutionalization naively implemented 3. services are hard for mentally ill homeless to find because they are not under unified jurisdiction 4. shelters are stop-gap and becoming mini-psychiatric institutions 5. needed structure is often missing in community 6. aggressive case management essential for this group 7. more funding needed
Levine, I.		Descriptive	services and programs for mentally ill homeless are lacking; the fact that so many homeless mentally ill on the street illustrates inadequacy of services for this group; an array of housing services needed.
Levine, I. Lezak, A. Goldman, H.		Descriptive	the Federal Community Support Program (CSP) appropriately characterized the needs of chronically ill through CSS programs and needs of population.

Source	Program Description	Study Design	Findings/Conclusions
Levine, I., Stockdill, J.		Descriptive	the number of homeless people is difficult to determine; significant numbers suffer from mental illness; factors contributing to homelessness: unemployment, lack of low cost housing, discontinuity of social services; mentally ill homeless unable to negotiate with service system in community.
Lipton, F.	100 consecutive patients treated at city psych. emergency room studies	Descriptive	majority of patients diagnosed as schizophrenic; heterogenous group, contributing factors: inflation, cuts in federal, state programs, lack of low cost housing, discharge policies over last twenty years.
Lipton, F., Sabatini, A. Katz, S.	100 consecutive patients studied at Bellevue psychiatric hospital emergency	Descriptive	heterogenous group. Contributing factors to homelessness: inflation, cuts in federal/state programs, discharge of patients from service psychiatric hospitals over a twenty year period.
Mayor's Conf.	Shared information; fact gathering	Conf. proceedings	homeless mentally ill need: emergency food, shelter, clothing, health services, housing alternatives, day centers, case management, outreach, coordination of community services.
Morrissey, J. Dennis, D.	NIMH summary of 10 most recent studies	Descriptive	majority homeless are a socially diverse population; homelessness not a mental health problem; social service system needs to be involved; what works with individual groups among homeless still an issue.
Morrissey, J. Levine, I.	Conference Report	Descriptive	Condensed version of NIMH Study and Findings; large proportion of homeless population suffer from mental illness; no single housing option will address needs, must be a range; criminal justice system replacing mental health system.

Source	Program Description	Study Design	Findings/Conclusions
Morse, G.	Overview of mobile out-reach for home-less people with mental ill health	Descriptive	outreach programs provide diverse services; interventions helpful for engaging "reluctant" clients are: attention on client's agenda, needs, helping client with basic needs, clear offers of help, "activity oriented encounters"
Segal, S.P. Baumohl, J.	Discussion/ description of "space cases," young male chronic mentally ill	Design Descriptive	recommendation for more stable supports; prediction of increase in young chronic mentally ill men on the streets in the 1980's.
Smith, Susan J.	Description of homeless person's death, who may/may not have been mentally ill.	Descriptive	Reagan Administration policy bears some responsibility for homeless people; it will take years for federal policy to keep up with needed low-income housing; mentally ill homeless require different approaches than the regular homeless population because they may be too disoriented to recognize that they need help.
Sullivan, J.		Descriptive	homeless mentally ill in public transportation facilities need outreach services to facilitate their receiving appropriate services; police are needed to protect mentally ill homeless from those who prey on them.

Table 7

CURRENT KNOWLEDGE CHART

This chart summarizes the current knowledge about homeless mentally ill people in an abbreviated format.

Findings from research

Deinstitutionalization (idea) retrospectively was appropriate:

> however the implementation has contributed to the homelessness of mentally ill people.

Homeless are a heterogenous group; minority group members are over represented.

Criminal justice system is housing many homeless mentally ill people.

Shelter systems, although temporarily necessary, function as mini institutions.

Cuts in social service programs have contributed to homeless problem.

Legal system needs to look at its current laws as they affect the mentally ill.

Policy is not synchronized with the mentally ill, thus people are still being released from hospitals with no place to go.

Mental health professionals need to get together on what should be done now.

Although both theoretical frameworks have been criticized more as catering to the worried well, the formulation of the theory by Mahler et al., in describing attachment seem to parallel what workers are attempting to do when they establish a relationship with a homeless mentally ill person.

In understanding object relations theory we need to view the way a newborn organizes his world, how he/she differentiates and organizes the self-self representation and object-object representation.

Horner's theoretical framework as she writes about the developmental object relations approach will be utilized.

> The term object relations refers to specific intrapsychic structures, to an aspect of ego organization, and not to external interpersonal relationships. However, these intrapsychic structures, the mental representations of self and other (the object), do become manifest in the interpersonal situation (Horner, 1989, p. 3).

Margaret Mahler's theory of separation-individuation, although originally developed out of research with psychotic children, then expanded to include normal development in children caused the researcher to hypothesize the stages in establishing a relationship with homeless mentally ill people as outlined below.

Although Mahler's theory was developed from her research with psychotic children and their mothers (Hedges), the theoretical framework was later extended to healthy children.

> Mahler's theory was formulated as a set of intrapsychic experiences in human development, a progression of phases and sub phases accounting for levels of development in the child's capacity for object relations (Hedges, 1983, p. 3).

Figure 8 below uses Mahler's theory to illustrate a perspective on how to establish relationships with homeless mentally ill people.

Horner (1989) addresses the issue of psychopathology in treatment of people with mental illnesses. The therapist, clinician or worker is trying to mobilize the resources the person has (ego strengths). She further indicates that a number of people with mental illness have egos which are not developed in the area of object relations.

Can any of these theoretical concepts assist in establishing relationships with people who are homeless and mentally ill? The selection of the above theory was chosen because they deal with theories of attachment and detachment. It is the author's assumption that attachment plays a crucial role in establishing relationships with homeless mentally ill people. Whether workers approach the task consciously or not, they attempt to make themselves needed, someone to be depended upon by homeless mentally ill people with whom they work to establish relationships.

Truax and Carkhuff focus exclusively on the psychotherapeutic relationship; how to train therapists on the use of the psychotherapeutic relationship. The value in examining their material is in understanding how a helping therapeutic relationship can be enhanced to bring about a desired end. They indicate three crucial aspects of the psychotherapeutic relationship which are: 1) empathy, warmth

Table 8

STAGES IN ESTABLISHING A RELATIONSHIP

Observation, provision of concrete needs (respect for normal autism)--let person have some time alone to talk to him/her self, privacy.
Worker demonstrates his/her helpfulness, usefulness, dependability, reliability. Worker becomes necessary to client.
Worker accompanies clients on appointments, interviews, teaching, modelling for client but allowing client to do things on his or her own when desired.
Client strives for self-sufficiency, seeking assistance when necessary.

and genuineness; 2) nonpossessive warmth, and 3) therapist's self congruence (Truax & Carkhuff, 1972).

Studies of many different types of help-seekers, including college underachievers, delinquent girls and hospitalized schizophrenics, show that all respond favorably to therapeutic encounters in which the qualities mentioned above are strongly present. They react unfavorably when the qualities are absent.

This theory, along with those of Vigilante & Mailick, 1988, Mahler, 1978 will be utilized as they articulate the components necessary in establishing a therapeutic relationship. The assumption is being made that the same components necessary in establishing relationships with homeless mentally ill people are as critical in the information of relationships among other groups.

Chapter 3

METHODOLOGY

Study Type and Methodology Congruence

This is an exploratory/descriptive study in which in depth interviews were conducted with 51 respondents (42 workers, 9 administrators), utilizing an open-ended question format, lending itself to elaboration and qualitative methodology analysis.

In addition to the semi-structured questionnaires, the critical incident technique was utilized. All respondents were asked to share two incidents associated with establishing relationships with clients, one that went well and one that did not. There were a few questions that respondents were required to select from existing choices, so that some quantitative methodology data analysis could be utilized. (See Appendix A for copy of structured interview.) The purpose of the interview was to collect data to be used for a workshop. This was explained to interviewees prior to beginning the interview.

Sampling Strategy and Plan

Purposive sampling was utilized for this project. The worker approached those programs that have reputations for working with large number of homeless people and who have reputations in service delivery arenas as the best. All

projects included are familiar with and have included in research projects previously.

Purposive sampling was also utilized as this is one sampling plan suggested for small samples in which the utility of information can be increased. (Patton, p. 105).

Originally, the researcher wanted to interview one client for every worker so that some cross tabulation could be utilized. Cross-referencing what workers said they did to establish relationships with clients with what clients said helped them to become connected. However, this plan was changed due to access to programs and client mobility.

Sample

Interviews with 51 respondents (42 workers, 9 administrators) explored and described how workers establish relationships with homeless mentally ill people. In the sample, 22 out of the 51 respondents were from Bellevue hospital. One could say that responses are skewed in favor of a hospital setting. Another perspective viewed by the researcher is that many of the programs that work with homeless people are small, approximately 2-4 full-time staff members, including an administrator who is in the dual role of worker and administrator. The largest service providers in New York City currently are Bellevue Hospital and Columbia University Community Services. The worker realized that the bulk of the worker data would come from one of these programs. However, the researcher visited as many different programs as

possible, regardless of distance and number of staff, so that diversity of opinion would also be included.

Sample Composition

Detailed information was not solicited from respondents other than on the variables of education and race/ethnicity. Forty-eight percent of the respondents had graduate degrees; 33%, had graduate credits; 2%, had two graduate degrees; 2%, received advanced standings in doctoral programs; 2% obtained law degrees; and, 2% medical degrees.

In terms of race/ethnicity of respondents 62% of the workers were white; 26%, African American; 10%, Hispanic; and, 2%, other.

Sample Size

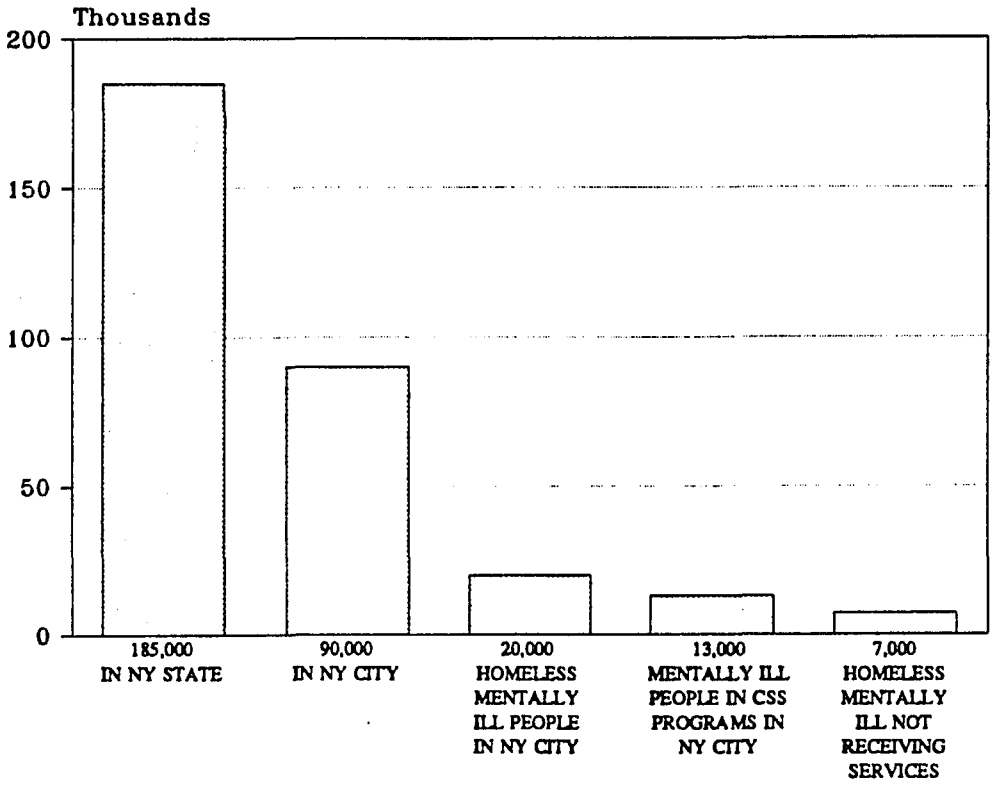
There are approximately 185,000 people in New York state with serious mental illness. Of this number, 90,000 or close to one half are said to be in New York City. Twenty thousand are identified as homeless and mentally ill.

For this 20,000 people, there are 80 agencies under contract with the Department of Mental Health, Mental Retardation, Alcohol and Substance Abuse. The 80 agencies provide services to 13,000 individuals through 133 programs.

The bar graph below illustrates the distribution of the mentally ill homeless individuals in New York state.

The project included ten of the 33 CSS programs in New York City or 21%. Small wonder that we see so many homeless

MENTALLY ILL PEOPLE IN NEW YORK



mentally ill people wandering in the streets, based on the above figures.

Restrictions

To obtain access to programs, and have the openness that was desired and achieved, no identifying information was asked or kept on any respondent. Some of the respondents expressed concern about sharing identifying information out of concern for giving the "correct or right" answers. Other respondents expressed mistrust of research in general and did not want to participate if identified. Still other respondents did not want the information they shared linked to them, as everyone was not aware of their perceived failures (with regard to the critical incidents). Each questionnaire was sequentially numbered, so that information could be coded, if needed, in data analysis.

The above was a deliberate decision involving a trade-off, access to information, respondents vs. data that utilizes quantitative data, methodology.

Data Analysis Plan

Despite the research goal of wanting to conduct a study utilizing quantitative and qualitative methodology, the project format is qualitative and utilizes methodology reflective of qualitative research.

There are problems with reliability and validity in qualitative research. To counteract the above a variety of techniques were used, questionnaires, interviews (in person

and one via telephone) and the critical incident technique. The ability to use any or all of the above aides in counteracting issues of reliability. "...for most evaluation problems - a variety of data collection techniques and design approaches will be used" (Patton, p. 60). Polansky, 1975, and Smith, 1989 address the issues of reliability and validity in qualitative research. They suggest the use of a variety of data collecting methods.

Worker-Respondent Flexibility

The worker interviewed respondents individually, in groups, stopped, started interviews whenever respondents were required elsewhere, followed behind them from location site to location site, inter and intra site. The format of the questionnaire was also changed to meet the respondents' needs. For example, one psychiatrist and one nurse did not have 45 minutes to one hour to spend talking to the researcher. Therefore, crucial questions and/or issues were extrapolated from the general questionnaire, with the critical incident question remaining a constant for all respondents.

Programs

Program Selection Criteria

All programs selected and included in the project are community support systems programs (CSS). CSS programs are state funded, city administered and have accountability to their funding sources and administrators. Respondents were drawn from the selected CSS programs.

The criteria for selecting the programs was based on: 1) differences in the subgroup of homeless mentally ill people that they served that might reflect different ways of establishing relationships; and 2) difference in how accessible the researcher would be with clients.

The researcher shared a general outline with the program respondent concerning information she was interested in and then left it to each respondent's discretion and time to share information. The general outline shared with respondents was program name, location, philosophy, history, services offered. Due to variations in each administrator's availability, time constraints and style, the information solicited is not presented in a uniform manner. Programs included in the study will now be described. The programs, location and number of respondents per program are listed in Table 9 below.

Antonio G. Olivieri Center

The Anthony G. Olivieri Center for homeless women is a drop-in center in Manhattan, opened 24 hours/day.

Brief History of the Westside Cluster

It was founded in 1981 as a drop-in center for homeless women in the Penn Station area. The center receives most, but not all, of its funding from the Human Resources Administration (HRA), and serves 70-100 homeless women daily, many of whom are mentally ill. The Center does not have beds, however, it provides transportation to church and city shelters. Women can and do choose to sleep on chairs at the

Table 9

PROGRAM LOCATION AND RESPONDENT TABLE

This table illustrates programs, locations and number of respondents.

Program	Program Location	# of Worker Respondents	# of Admin. Respondents	Total
Olivieri Center	03	01	04	
Bellevue (two programs)	Manhattan	18	04	22
Reachout	Manhattan	04	04	
Columbia Presbyterian	Manhattan	03	01	04
CUCS two sites	Manhattan	05	01	05
HOP	Manhattan	02	02	
The Bridge Project	Manhattan	02	01	03
TLC	Brooklyn	02	01	03
Totals		42	09	51

center, preferring not to use city or church shelters. Three meals a day are served, with the women participating in menu planning.

The philosophy is grounded in the value of helping the homeless individually, one person at a time. Providers build on the person's strengths, while being aware of difficulties. The philosophy of the Westside Cluster, of which the Olivieri Center is a part, is to assist chronically homeless mentally ill women by developing: 1) secure and inviting environments that encourage trust and positive self-esteem, 2) provision of high quality concrete services and intensive case management.

Bellevue Hospital

Bellevue, a large municipal hospital in an urban environment, has two Community Support Systems (CSS) programs which were utilized in this project, CSS I, case management, and CSS II, continuing treatment program.

Founded in 1736 as an infirmary in lower Manhattan, some contend that the hospital's history can be traced to 1658 when five company workshops of the Dutch West Indies Company were donated for hospital use (Bellevue Hospital Press Kit, 1989, p. 1).

In 1970 hospital management was taken over by New York City Health and Hospital Corporation. Probably best known for its psychiatric, medical services. Bellevue, in keeping with its mission to provide services to the sick and poor, responds to and hones its services to societal problems. One such

societal problem is the influx of mentally ill homeless people. In 1987, through funding from Community Support Systems (CSS), Bellevue opened two Community Support Programs, case management and continuing treatment.

Case Management

The case management program provides outreach throughout the hospital community to any client/potential client who is homeless and mentally ill. The services are: assistance in obtaining entitlements, escorting clients to and from appointments, psychotherapy and/or referral for psychotherapy, follow through and follow-up in the provision of whatever identified needs clients and worker have outlined, case management.

The program is located in the main lobby of Bellevue in a series of prefabricated offices. The continuing treatment program (CTP) started in 1988. It provides psycho-rehabilitative services within a discrete setting of an older Bellevue building, now utilized predominantly as a city shelter for mature, infirm men. Services consist of case management, task-oriented, supportive therapy, psychoeducational services, advocacy, brokering, counseling, medication and medical evaluation. At the time of interviews, there were five workers, a nurse and a psychiatrist.

The program capacity is 45 clients per month, and the average length of stay can be longer ranging from one month to one year.

This is a 24 hour per day, 7 days a week program.

The philosophy of both programs is that staff make themselves available for talks with patients about helping with patient needs: housing, food, medication, medical treatment. Each person is approached in a humanistic manner. They are viewed as having rights, needs, and problems.

The relationship between worker, patient/client is seen as a partnership. Therefore, both programs are voluntary and no incentives are promised for coming to the program, with the exception of staff who will work with a person toward his/her goals.

Clients are diagnostically the same in both programs: they have major psychiatric disorders on Axis I, mainly schizophrenia, major affective disorders, and atypical psychoses.

Workers

There are eight workers in the case management program who are assigned to various hospital units and/or accept referrals from anywhere within the hospital system.

Project Reachout

Project Reachout began as a mobile outreach program, providing services within designated parameters on the upper west side of Manhattan, including a large municipal park. The services have expanded since 1979 to include: case management, money management, housing for homeless people, including

building management, a day program, in addition to mobile outreach.

Project Reachout offers food, showers, medical and psychiatric services, financial assistance, case management, temporary shelter, and a "welcoming place to come, sit, and have a cup of coffee" (Project Reachout Brochure, 1989, Blue edition, see Appendix . Brochure in revision stage at time of study). They also refer clients to drop-in centers, day treatment programs when appropriate.

The street and park outreach teams go out in vans at popularly scheduled times. They offer brown paper bags containing a sandwich, juice, and dessert to homeless people. The bag also contains the name and telephone number of the program.

The brown paper bag and its contents are viewed as a tool toward gaining the trust of mentally ill people living in the streets and parks.

The project is located in a suite of brightly lit offices on the upper west side.

The clients range in age from 20 to 60. Psychiatric diagnoses of clients are predominantly schizophrenia, major-affective disorders, and personality disorders, with the majority of the clients having chronic mental health problems.

Goddard Riverside

Goddard and Riverside are extensions of the settlement movement of the 1800s when Anglican priests went to the East

End of London, and were appalled by the way the largely eastern European immigrants were living. They brought students from Oxford and Cambridge Universities to the area and started educational programs to work with the immigrants. The American settlement house movement, in contrast, appeared to be more focused on social reform. In 1958, Goddard (34th & 1st Avenue) and Riverside (Broadway and 64th) merged due to changing community needs and urban redevelopment.

Goddard and Riverside merged their two boards and bought a brownstone on West 85th Street in Manhattan. When public housing was built in the area, they sought and received space in public housing for day care, and have been expanding services in response to community need ever since.

Philosophically Goddard Riverside is concerned with how to get people in a neighborhood to live together. How do you transmit values in the 1990s meaningfully so as to enhance the "richness of diversity." (Wohl 1972, p. 1-2)

Riverside is grounded in a value system with six concepts:

1. Community of culture and concern. The involvement of all segments of society is sought in the improved quality of life for all.
2. Richness of difference. Differences in race, class, religion, sex, age, beliefs, and backgrounds are sought for enrichment and cross fertilization.

3. Freedom and responsibility cannot be separated; with freedom there is acceptance of social responsibility.
4. Conflict and struggle are as important to the creation of a community as culture is to life.
5. Celebration, the act of sharing a range of emotions with others is the complement to the resolution of conflict; celebrating the fact that you're alive in spite of difficulties is important.
6. Goddard Riverside is a laboratory for social change. Thus experimentation can result in success or failure. Risk-taking and self-examination are crucial in the laboratory atmosphere.

In 1978-79 the city's office of mental health approached the executive director about providing outreach services for homeless people in the area. In addition to the city's approaching Goddard Riverside, the Board of Directors asked the executive director what Goddard could do to respond to the needs of homeless people in the community. Thus in 1979 Goddard Riverside began Project Reachout in addition to the myriad of other programs they have: day care, education, camp, and senior citizen programs.

Columbia Presbyterian Shelter Day Program

Fort Washington Men's Shelter

The Fort Washington Men's Shelter was opened in 1979, as an attempt by the City of New York to comply with the consent

decree, 1979, and to meet the increasing demands of homeless men in New York City. The consent degree made the city and state of New York responsible for providing emergency shelter for any man age 18 and above; the decree later was expanded to women. There is the congregate shelter and within the shelter is a separate CSS program.

In 1979 the CSS unit was opened as a result of the number of men who appeared to have mental health problems. Columbia Presbyterian Hospital's psychiatry department sponsors the shelter program, providing staff, in-kind services, and material.

The program provides: psychosocial counseling, medication, rehabilitation, nursing/medical care, recreation and case management to all men enrolled.

The day program, in keeping with its role as a CSS program, maintains a low demand, low stress atmosphere. Clients are treated individually, and in groups with the ultimate goal of helping them locate appropriate, permanent housing, and maintaining themselves in the community, once housed.

The Columbia program also reports on a phenomenon they have observed, shelterization: those behaviors that clients learn/adapt in order to survive in the shelter. However, these same behaviors are not helpful in the transition to community living. (Valencia, 1990) The staff works with men while in the shelter to make the transition to independent

living in the community, and to maintain themselves, once there.

The Presbyterian Hospital Homeless Outreach Program (H.O.P)

The Homeless Outreach Program, (H.O.P) of Columbia Presbyterian Hospital began in 1989 as a result of the increasing number of homeless mentally ill people in their community, and a referral source for its community support systems, (CSS) program located in the Fort Washington's Men's shelter. Columbia Presbyterian found that homeless mentally ill people frequently do not get the services they need, because of disaffiliation, and/or rejection of offered services. Thus, H.O.P.'s mission is to assist homeless mentally ill people in the hospital's neighborhood by gaining their trust, and linking them to needed services.

Location

The program is located on the 3rd floor of an elevator operated hospital clinic building, that is approximately one block from the main hospital building.

Philosophy

H.O.P. works with all homeless people within their geographic parameters toward achieving their goals, ultimately attempting to secure permanent housing.

Staff

The staff consists f a master's level social worker, psychiatrist, nurse, and a paraprofessional.

Workers

There are nine bachelor's level workers in the case management program who are assigned to various hospital units and/or accept referrals from anywhere within the hospital system.

Continuing Treatment Program

The continuing treatment program (CTP) started in 1988 and provides psycho-rehabilitative services within a discrete setting of an older Bellevue building, now utilized predominantly as a city shelter for mature, infirm men. Services consist of case management, task-oriented, supportive therapy, psychoeducational services, advocacy, brokering, counseling, medication and medical evaluation.

The program capacity is 45 per month, and the average length of stay is 150-160 days. However, the length of stay can be longer, ranging from one month to one year.

This is a 24 hour a day, 7 day a week program.

Columbia University Community Services (CUCS)

Columbia University Community Services (CUCS) has provided services to homeless individuals since 1980. The organization is sponsored by the University and administered by the School of Social Work. In addition to direct services to homeless people, it provides training opportunities for students attending Columbia interested in professional careers in human services. CUCS works exclusively with homeless

people. (Columbia University Community Services Overview, 1989)

Programs

CUCS programs are: 1) Residential Programs: The Edgecombe, Delta, Stella Hotels, and the Heights; 2) transitional service programs, a transitional living center and a drop-in center; 3) Consultation, education and a computerized housing service, Residential Placement Management System (RPM). This later service assists other provider agencies in their efforts to place homeless mentally ill people from the shelter/street into permanent housing. The researcher investigated two of the residential programs as these were the two programs offered currently, available for research or the Columbia University perspective would not be included.

The Delta

The Delta opened in 1989. It is a permanent residence for homeless people. It is an integrated housing model, where at least 30% of its occupants are diagnosed as having mental illness. Social services are provided on site by a team of three staff members, supervised by a masters level social worker. There are a number of single rooms in the Delta with a communal living room area equipped with comfortable chairs, and a television. The Delta does not provide meals, however people can cook for themselves/others in one of the community kitchen areas on each floor. The Delta is conveniently

located to public transportation, on a wide thoroughfare in Manhattan.

Many of the clients at the Delta have dual diagnosis, mental illness and chemical dependence.

The Heights

The Heights, located in upper Manhattan, is one of the first models of permanent housing for homeless people in New York City. Building management is separate from the social service team which is located in the building. Approximately 30% of its residents are diagnosed as mentally ill. The residents come from a variety of referral sources including shelters, the street, social service and client referrals. Potential tenants are interviewed four separate times by the building management, the social service unit (2 times), and tenants already living in the building. This co-opting process in decision making gives everyone an interest in the potential client's success in the building. The Heights is conveniently located to public transportation. There are 72 single rooms in the building, 12 rooms per floor and a spacious backyard area.

There are four staff members on the team led by a master's level social worker.

The Bridge

The Bridge, Inc. was established in the 1950's by a group of former mental patients with the purpose of assisting former/current mental patients to make a successful transition

to the community. It has developed into a community based program which operates 365 days/year. The overall purpose/goals to provide mental health and rehabilitation services to chronically mentally ill adults has not changed. In 1984 the Executive Director of the Bridge was requested by the Board of Directors to explore the possibility of working with homeless mentally ill people. Over the next 18 months the Bridge had a pilot program for homeless mentally ill people without separate funding. In February of 1986 the program was funded by Community Support Systems (CSS) contract.

The Bridge program philosophy is grounded in several theoretical concepts:

1. The provision of housing alone to mentally ill people will not achieve a successful transition from the shelter to the community.

2. Establishing/reestablishing attachments need to proceed the shelter transition.

3. Establishing social attachment requires time.

4. A non-traditional program approach is needed for homeless mentally ill people.

5. A positive collaborative relationship with shelter staff is crucial.

6. Client concrete service needs must be med.

7. On going support services needs to be maintained.

The Bridge has outpatient day programs for housed and homeless mentally ill adults, scattered-site housing, permanent residence, thrift shop, medical health assessments and case management. In addition to the Day programs for housed and homeless clients, the Bridge's services include a vocational program, supportive work program on site, an evening/weekend program, services programming, food services during weekend and evening hours, hospital transition program, where selected clients are brought from a psychiatric facility to attend the Bridge Programs, aiding in the transition for the hospital to the community; mental health clinic providing individual therapy, medication (by prescription), community residence program 24 hour supervised housing, health clinic, providing individual therapy, medication (by prescription.

The homeless day program differs from the regular Bridge day program in: 1) the regular program uses a more traditional mental health approach to mentally ill people, involving structured intakes upon referral/entry into the program, while the homeless day program waits to gather psychosocial information (that they do not have) unit the client is more comfortable with the program, environment and staff; 2) the homeless day program is aimed at helping clients' transition from the shelter to the community. The homeless day program, while assessing and enhancing current ego functions, attempts to engage clients in mental health treatment.

The clients are currently African American, White, and Hispanic. The major diagnostic category is schizophrenia. Other diagnoses range from Axis I, DSM IIIR, including major affective and personality disorders.

Each client has an individualized program which staff and clients participate in the planning of, once the individual becomes acclimated to the setting, routines, other client activities. Activities range from cards, board games, culture groups and trips.

There were four full time staff members at the time of this research which was supplemented by interns and volunteers. The way the program is physically and philosophically set up, clients have access to staff for 8 hours a day. This access facilitates the attachments and bonding between clients and staff.

The Bridge day program is located in the Executive office of t Bridge Inc. (on a separate floor) in a newly renovated building on Manhattan's upper West side. The Bridge is conveniently located close to transportation. In addition, they have a van which is utilized to transport clients.

Brooklyn Bureau of Community Service (T.L.C.)

Brooklyn Bureau of Community Service, founded in 1866, is a voluntary non-sectarian, not-for-profit agency which provides social services to families, children, disabled men and women seeking ways to be more productive to themselves and their community.

T.L.C. is a 24 hour comprehensive care program located in a city shelter in the East New York section of Brooklyn New York. They work with homeless mentally ill women providing an array of mental health, and rehabilitation support services including: case management, individual and group counseling, education, recreation activities, advocacy, referrals for medical care, psychotropic medication, substance abuse services, referrals to appropriate community agencies.

T.L.C. works towards helping the client meet her goals, with the ultimate goal of trying to locate permanent housing for all who are in the program for the five month stay.

Program Distinction

Although all CSS programs have the same standards, each also had features, distinct from the others. Chart 10 below is an attempt to illustrate the distinguishing features of the program (researcher perspective). It is not an attempt to be comprehensive, only to indicate the most striking differences from the researcher perspective; the issue of what makes each program unique.

Process

The process of arranging the interviews involved two approaches depending on whether the researcher knew/had worked with someone in the setting or was referred by someone mutually known to the researcher and potential respondent. If the worker knew someone at the site, the process involved: 1) a telephone call explaining the purpose of the call, the type

Table 10

PROGRAM DISTINGUISHING FEATURE TABLE

Program	Distinguishing Features
1. Bellevue	voluntary hospital setting (2 programs)
2. Bridge	day program with housing
3. TLC	safe haven in a shelter
4. Columbia Presbyterian Shelter Program	shelterization
5. HOP	street outreach with hospital backup
6. Project Return as engagement tool	street outreach with brown bag lunch
7. Columbia University model Community Services	permanent integrated housing (2 Programs)
8. Olivieri Center	drop-in center with a three step approach

of project and request for participation, arrangement of interview time, follow-up letter of confirmation. (See Appendix). 2) If the researcher had not met the potential respondent and/or had no connections with the site, formally or informally, a letter explaining who the researcher is, requesting participation in the study and notification of the follow-up telephone call was mailed.

Once interview times were arranged the worker arrived at the sites with an interview schedule, interviewing only those respondents who had time, were interested and/or referred. Interviews were usually conducted individually with three worker respondent exceptions: 1) one group interview, as all case workers were interested and available at the same time 2) one telephone interview. The researcher would purposely arrive to the area of the site early, to observe any activity which may/may not be useful for inclusion, find out how easy/difficult it is to travel to the site. All respondents were informed that their responses were confidential; each questionnaire was numbered without names. The purpose, product of the project, anticipated amount of time needed for the interview; researcher flexibility in case we had to stop and start again in the course of interviewing due to other issues respondents had to attend to was shared with each respondent.

Researcher Accessibility

The researcher had no problem with accessibility to programs approached. All programs contacted agreed to participate, were open and honest about concerns that clients not be misused in the process, were generous with their time, coffee and personal referrals. The researcher made a concerted effort to be flexible, non-intrusive, verbally appreciative, and follow program ground rules. For example, in some settings clients approached the researcher, held conversations, and in general wanted to know who she was and what she was doing there. In these settings the researcher was expected to respond and interact. In other settings, the ground rules were different; no client interaction, except for greetings.

Respondents were asked a schedule of questions so that overall project goals could be addressed: How do workers specifically establish relationships with people who are homeless and mentally ill? What is the state of practice knowledge in establishing relationships with this group of people?

The instruments for the project with rationales for questions are located in the Appendix.

Client Inclusion vs. Access

The researcher originally wanted to see if there was any association between what workers said about establishing relationships and the factors clients said caused them to

become connected with or have a relationship with a worker. However, several issues caused the researcher to abandon this idea: 1) homeless mentally ill people have been studied, interviewed, yet services and care do not follow quickly, and in the necessary quantity. The researcher did not care to join the legion of researchers with no concrete offer(s) or solution(s); 2) ideologically, it does not seem correct to continually study people with no potential gain for them; 3) some administrators would not permit client-researcher interaction except under particular parameters, partly as a result of their opinion that action and services are needed vs. continued study, a perspective with which the researcher agrees. The researcher would not have gained access to these programs, without prior agreement. Therefore, the decision was made not to include clients.

The researcher could not provide housing or a substantial monetary return for clients. In addition, some administrators would not allow the researcher to interview clients. Therefore for uniformity, no client interviews were elicited or included.

How Data Was Analyzed

Data was analyzed by using a technique that most appropriately coincided with how the data was collected. This is a qualitative exploratory study with some questions that lend themselves to quantitative data collecting methodology. Most question responses were grouped, then the researcher

looked for similarities and differences in responses. Data was organized into a table format, as Table 11 below, and the researcher looked for immediate visual central themes and variations. Once in this format again the researcher examined the material for central themes, similarities/differences.

Answers, variables, in addition to issues/themes which had not been identified were always of concern: 1) knowledge, 2) skills, 3) education, 4) steps/procedures, 5) ethnicity, 6) what works (from critical incidents).

Table 11

DATA ORGANIZING CHART

This chart illustrates how data was organized, prior to analysis.

QUESTIONS	RESPONDENTS 008	009	010	011
2	Yes.	Yes, definitely. Understanding of the type of people and needs.	Yes.	Yes. Personally aware of people/ psychopathology.
3	Assessment, being able to see what they need.	Self acceptance, can't begin to accept qualities in others that you have not accepted in yourself.	Observations, listening, develop rapport at social service agencies.	Perseverance, patience frustrated on so many levels.
4	Same as question 3.	Patience.	Patience.	Perseverance, frustrated on so many levels.
5	Establish a relationship.	Ability to love self first, that will radiate up to what you're doing with people who are shattered, fragmented.		
6	Willingness to work with mentally ill homeless, handle the smells, to be able to accept, not too many thanks, a degree education (not specific).		Good amount of self-awareness.	Willingness to hear.
7	Important that you show boundaries between client and worker, not necessary to make things clear; not a romantic relationship helps to keep you from being manipulated.		Being able to find whatever venue a person allows you to meet them on. Art, music, just sitting, being in your company.	Flexibility. Focusing concrete services.
8	Psych terms, DSM3R	Hard to separate what's knowledge and what's a part of being, counseling and group work.		Psychopathology. Part of being.

Chapter 4

DATA ANALYSIS

This chapter presents how the data was analyzed. It is organized by conceptual frameworks, using quotes from workers and administrators to illustrate findings. The frameworks are: education, knowledge, skills, steps and procedures and ethnicity. They are presented in categories contributing to the establishment of positive or negative relationships.

Variables

Several variables were of particular concern to the researcher, the connection, if any, among skills, education, and knowledge in establishing relationships with people who are homeless and mentally ill. Are particular steps/procedures necessary/followed? What information can be learned from the critical incidents? Are there practice principles that workers use?

Data results will be presented in the order outlined above.

For the purpose of this project, distinctions are made between skills, practice skills and clinical skills.

A skill, as indicated earlier, is defined as something workers do in the process of achieving client-worker goals.

A practice skill is defined as something workers do with or for clients which relates to a specific body of knowledge (social work and/or counseling).

A clinical skill relates more specifically to techniques connected to a body of knowledge that is designed to create movement or change in the client. This movement is usually emotional movement which may or may not be a barrier to physical movement.

Skills

In response to the question are special skills needed to perform your job, 41 out of 42 respondents answered affirmatively (98%). The one respondent who thought no special skills were needed said what was more important is an "innate ability to relate to others." In addition, he felt that this could not be taught, "you either have it or you don't."

Those who affirmed that skills were needed were asked to specify what they were/are? Are the skills the same as those for all other clients in need of social services? Are these skills those that anyone can acquire?

For the purpose of this project a distinction was made between skills and knowledge. This distinction was explained to respondents prior to asking related questions. Skill was defined as something the worker does (active), while knowledge was defined as information obtained from a book, article, printed material or classroom setting.

Most respondents felt that having an innate/intuitive ability to respond to verbal and non-verbal cues helped to facilitate establishing relationships. The issue that came up frequently concerned the worker ability to "tell", "read", or

"feel" when they are "too close," "invading someone's personal space, unless invited to. The comment below is indicative of the above.

> I try to be very careful of this. I have seen workers almost walk right into a person, to show, I guess, that they are not afraid; in the meantime the client is taken aback because the worker just went over the personal line.

Workers need to be aware of boundaries so they can find ways to help clients accept boundaries.

> One should usually approach a person from the front, not the side, stop when they feel the client needs you to or you feel you need to.
>
> I haven't the slightest idea how you would teach this; it's from the gut.

All of the skills have been identified by Rog (1986) with the exceptions of assessment, verbal and written ability, ability to accept personal rejection and the importance of the relationship.

Practice Skills

Workers emphasized the worker ability to listen, observe, make assessments, empathize, be non-judgmental. Further they spoke about flexibility, workers needing verbal and written skills, and having the ability to communicate with a variety of professionals and paraprofessionals in medicine and psychiatry as well as with all people.

The following is a series of themes derived from respondents' comments:

Being able to establish relationships with clients and other workers was important.

- Try to establish positive relationships.

- Workers make the assumption that whatever they are doing has not been tried before -- wrong assumption, it has. The clients have seen and done it all before. It is the relationship that is crucial. Workers need to spend more time with it (relationship), and do their work with family and exploring housing options.

- Perseverance, ability to develop rapport with workers at social service agencies. Relationships with the client are just one part of the relationship issue. You need to develop positive relationships with workers at social service agencies also.

Being able to stay in sync with the client's pace is crucial.

- I know it sounds corny, but start where the client is.

- You can't go faster than the client is willing/able to go.

Listening, patience, observation and self acceptance were also spoken about as workers identified traits that helped them to establish positive relationships.

- Observation listening, a tremendous amount of self-acceptance; you can't begin to accept qualities in others that you have not accepted in yourself.

- You can't be judgmental -- the client has to feel that sincerity from you; you can't shy away from someone because you just saw them rummaging in a garbage can.

- Learn to listen to what the person has to say.

- Patience, be able to listen.

- Many of the people who we come in contact with, in addition to their homelessness, have many years of untreated medical problems, due to lack of finances, ignorance. I think it helps if you can spot medical issues during your assessments. (Respondent was nurse: feels workers should look for and understand symptoms of eye color, smells, sores.)

- Sometimes I don't know if it is a skill or an attitude; don't be afraid to get your hands dirty (literally and figuratively).

Clinical Skills

An artificial distinction is being made between types of skills. A clinical skill is being defined as one in which concrete knowledge has been acquired prior to performance; a transferable skill, in contrast, is one which can be acquired through continued observation, or it could be a personality trait.

Clinical skills identified by workers seem to be in the areas of crisis intervention, counseling, written and verbal communication skills. Clinical skills require knowledge and/or practice. Listed below are some remarks by workers as they discussed the importance of crisis intervention skills, knowing how to establish a relationships and self knowledge:

- Crisis intervention
- How to intervene when you see conflict situations budding (client arguing, situation could escalate into physical confrontation).
- Being sensitive, yet firm.
- Establishing a relationship.
- Empathy, even if you don't obtain the concrete services, it doesn't matter. If you're warm and open that will help; most of the people are so starved for being treated like human beings, that empathy and warmth go a long way.
- Sense of identification with them. You're working with people, not dollars and cents.
- Concern for the client.
- Convey to people that you honestly care.
- Consistency, follow through.
- Self-control.

One issue that did not fit in any of the outlined categories was the coping mechanisms of the workers. Workers mentioned that one way they cope with recidivism (repeat clients) is for the worker to have a sense of self. Sense of self in this context will be defined for this project using J.S. Mead's definition: One's sense of self is formed through an interactive social interactive process; it is changeable.

Personal Characteristics

Workers articulated personal characteristics apart from knowledge or skills. The personal characteristics were centered around listening, being consistent, patient, having interest outside of work, and coping mechanisms. Listed below are some comments on this issue:

- Ability to listen to the person and hear what they are saying; patience.
- Don't get wrapped up in the job or yourself, to the extent that if the client does not do what you want, you feel devastated.
- Have a life outside of work; you see a high degree of recidivism in this position, and having something to do outside of work (which you like) helps with accepting this recidivism.

Workers also emphasized the importance of establishing a relationship, worker consistency and empathy.

- Consistently, try to be supportive.

Basic counseling skills, perseverance and empathy were also key issues for workers.

- Counseling skills.

- Perseverance, you get frustrated on so many levels, yet you can't accept no for an answer; you have to figure out a way.

- If a client comes to you and expresses a need, they're in crisis; show empathy for the person.

Skills that workers identified are outlined in the Table 12 below.

Table 12

SKILLS TABLE

This table outlines the skills workers and administrators presented.

Clinical	Transferable	Personal Characteristics
Assessment Written and verbal communication in psychological terms	Listening Empathy Observation Flexibility	Patience Perseverance Creativity Knowledge of self
Dealing with resistant clients	Being non-judgmental	Self-control
Crisis intervention Counselling		

Skills Workers Need Prior to Job (See Table 13)

Most workers felt that any worker performing the job needed to bring to it the skills of: communication, assessment, perseverance, observation, flexibility and an ability to accept a rejection from the client. Listed below are comments of workers in response to skills they felt a worker needed to have prior to performing their job:

- Patience, tolerance for rejection, ability to see the big picture. Small gains are important...be able to say to yourself, in six months this guy has come a long way.

- Ability to understand that people come from different circumstances, don't be shocked by what you see.

- Don't be judgmental...don't shy away from someone just because they have just eaten from the garbage can; know how you're going to deal with situations like this...what will you do?

- Being well grounded in reality yourself, have some expectations in conjunction with knowing you're dealing with a crazy person and social issues of homelessness. There are not enough places. There is not a room for everyone you meet. You decide who can make it in this program and who can't.

Communication, flexibility, creativity and self control were also skills workers felt someone needed to perform the jobs.

- Communication, listening and getting through.

- Being able to talk to people, relate, just to talk about anything... weather, something you saw, anything.

- Ability to shift gears, flexibility.

- Creativity, e.g., one woman did not communicate at all, but she did express concern that a cat (in the program) was not eating enough, so we started talking about the cat, and eventually she joined in the program activities.

- Self control. You see so many things that will affect you emotionally. You have to balance things.

- Listen to the person, be able to hear the words, while deciphering the crazy stuff.

- Assessment. Figure out what the person needs, what are they asking for.

Additional skills workers focused on were: empathy and self-awareness.

- Empathy. You have to get in touch with what it must feel like to be living like this. Once you do this, you can try a little harder and one more time.

- You have to know who you are. Clients can pick it up right away. ...If you're smiling, and the person's smell is offensive to you, (you're straining) it's a phony smile.

- You can't begin to accept qualities in others that you have not accepted in yourself.

Self Knowledge

In talking with workers about issues brought up without the questionnaire, some workers, those who had time, were able to explain why self knowledge was important. For example, a worker with back concerns felt if she was not cognizant of her concerns this would be a "great manipulative thing" (a way for clients to manipulate her).

This worker had herniated spinal discs which were more painful to her if her body was in particular positions. She recognized she had the capacity for over-identifying with clients who may have expressed concerns similar to hers (back pain). This worker verbalized awareness of the above as she felt some clients may try to manipulate her to receive favors because she was so attuned to anyone with back pain.

Workers had varying and strong opinions as to the most important skill. Some felt empathy, flexibility, creativity, sense of humor, how to engage without letting psychopathology interfere, assessment and follow through were the most important. Other workers emphasized observation, listening, perseverance, counseling skills, objectivity - having an open mind and the ability to relate to people. Other workers felt patience, self control, knowledge of self, engagement, being non-judgmental, ability not to be shocked, not to stereotype people, knowing when to speak and when to remain silent, recognizing when to approach someone, communicate...that you care verbally were most important skills to them.

The most important skill for workers varied among: assessment, empathy, self control, and engagement (to talk, keep a conversation going).

Other respondents had not thought about this question before. "Who has time to think about that, you just do."

An argument could be made that some of the variables listed above are not skills. However, if the researcher asked respondents specifics about what they do, the listing includes the actual activity/ies that workers do, and felt the performance required special skills.

Most Important Skill in Performing Their Job

Workers expressed the most important skill to be the need to make an immediate assessment about the client's and their (personal) boundaries and the ability to judge how close they

should physically get to a person. Other workers expressed that what helped them the most in working work well with this population are: being non-judgmental, not having the tendency to stereotype people, "because someone is schizophrenic, it doesn't mean there is nothing unique about him." Other themes that appeared repeatedly were: self-knowledge, flexibility, persistence. Table 13, listed below illustrates the skills.

First and Subsequent Meetings

Thirty-seven respondents (workers) said their first meeting with the client is different from subsequent meetings because they are trying not to

> frighten the person away, hoping the person will listen to what I'm saying, while I hear what they want...Of course the first meeting is different. It is just like life. You're trying to make an impression (good one). Except here the stakes are higher. You may not get a second opportunity. If you didn't make a positive impression the first time the person may run from you/hide the second time.
>
> In the first meeting, they might be accepting of you, but not ready to develop trust; trying to know you as well as you know them (they think you know them). You cannot use that first meeting as your entire evaluation.

The previous section discussed worker first and subsequent meetings with clients. The next section will discuss education. Workers expressed that education is not as crucial as the worker's personality, creativity, and ability to accept rejection.

Tables 14 and 15 illustrate the educational background of workers (Table 14) and administrators (Table 15).

Table 13

MOST IMPORTANT SKILLS

Variables	Number of respondents
non judgmental	1
empathy	5
creativity	1
perseverance	1
knowledge of self	3
engagement	5
assessment	5
perseverance	2
compassion	3
patience	3
listening	2
consistency and follow through	3
observation	3
humor	1
knowledge of psychopathology	1
Total	39

(3 did not respond due to lack of time)

Table 14

WORKER EDUCATION TABLE

The education of all worker respondents.

Education	# of Workers	Percentage
College degree	19	48%
Graduate degree	14	33%
Some graduate credits	03	07%
Two graduate degrees	01	02%
Doctoral degree	01	02%
Some doctoral credit	01	02%
A.B.D. (all but dissertation)	01	02%
M.D. (medical degree psychiatrist)	01	02%
J.D. (law degree)	01	02%
Total	42	100%

Table 15

ADMINISTRATOR EDUCATION TABLE

This chart illustrates the education level of administrators/respondents.

Education	# of Administrators
Doctoral degree	2
All but dissertation (ABD)	1
Graduate degree	6
College degree	0
Total	9

Education

The issue of education of workers will now be addressed. Workers and administrators both felt that education has a paradoxical effect on workers' ability to establish relationships with homeless mentally ill people, and that education does have a bearing on the workers creativity in establishing and maintaining the relationship.

> I've seen people come and go here. One man with two masters degrees lasted one day. There is another lay person without a degree; the clients love her.
>
> Some people with degrees feel they have arrived, and they don't need/have time for this.
>
> It depends on how the person uses the education to relate and be creative in the relationship process.
>
> Education impresses one's colleagues, results make the difference to clients.
>
> The more education, the harder it is for the worker to relate. Personalities also enter into this equation.
>
> How do you accomplish that? I'm loose, usually not tense or overly anxious when I meet anyone new. The client can look at me and see I am not trying to hurt or intimidate them. I smile, chat, don't get too close physically, yet close enough so that the person knows I'm not afraid of them. I'm not a 'jerky person, stand still, keep my hands where the person can see them. It works for me.
>
> There was one time it didn't work -- establish a relationship. I know why now also.
>
> ...There was a client who was always smiling, other clients complained that he stole from them, taunted them, made sexual remarks towards them when staff was not around. Then one day he came in the bathroom while I was on the john, refused to leave. I had to get up, pull up my clothes, escort him out. He then began to taunt me about being overweight. His type of psychopathology could not make it here.
>
> Education meant nothing in this instance....The most educated missed the whole picture of who he was (assessment).

Workers and administrators spoke about the inverse relationship between education of the worker and the efficacy in establishing a relationship with homeless mentally ill people.

Workers said that at times the higher the education of co-workers, the more difficult it is for them to relate to the client and to show and participate in the repetitive, almost mundane persistence one needs "to show" to the client that you (worker) are sincere, can be trusted, and are worth listening and talking to.

> Education helps with the paper work, not the people connections.

> It depends on how one uses the education. I think aspects of the personality are more important than education. These aspects of the personality are: flexibility, ability to convey optimism, hope, empathy, being real.

Knowledge

There was general agreement that knowledge needed to work with homeless mentally ill people concerned recognition of major psychiatric mental illness diagnostic categories, recognition of alcohol and substance use and the ability to distinguish between mental illness and alcohol/substance use. Workers thought that this knowledge helps workers not to become frustrated and give up when clients did not respond as workers feel they should. The knowledge identified by workers was understanding of the DSM3, DSM3R, psychopathology, assessment and basic counseling skills.

Twenty-one percent of workers answered affirmatively to the question - was there any course in school which prepared you for your work today? Ten workers said there was no course which helped them; three were not asked, three were not sure. The courses that workers identified were: psychology, basic social work skills, basic counseling skills, abnormal psychology, and knowledge of substance use.

Steps and Procedures

Despite the fact that the majority of the respondents said that they do not follow any steps/procedures in establishing a relationship with homeless mentally ill people, all of the workers talked about following some routine that included much of the same components. Namely, 1) observation of one person in situation/environment, 2) greeting to the person, 3) clear offer of help and explanation of purpose/how they could help, 4) give necessary space by reading body language/verbal clues, 5) listen for what person needs help with, then see how/if you can be helpful within your (agency) parameters, 6) be consistent, come by and see the person the same time each day/week, 7) be and look pleasant, 8) show warmth, interest, genuineness, "be for real."

They thought that their "ability to form a relationship was helped by ability to make an immediate assessment, which is flexible, as to: person's sense of boundaries, dangerousness," "what client wants and needs which may be two different issues."

The worker expressed that the ability to express warmth, genuineness, empathy - can be done in their voice tone, body language, and consistency. Workers said they tried to always be cognizant of the lurking reality that this may be a "one shot deal". They had to make a favorable impression on the client, seem like a caring, interested person in this first encounter, because in some settings there may not be another opportunity. For example, on the street; if the worker has come across too much as a "busybody" or "interrogator," the client will run literally and figuratively from you; change locations where they sit/stand. "Workers cannot find them."

Workers in three settings had slightly different ideas about steps and procedures, as outlined below.

In Street Outreach

Steps and Procedures

Greeting.

Introduction.

Don't crowd.

Don't demand anything.

Don't infringe on delusions. Accept them for who they are.

Offer a sandwich.

In Day Care Settings

Greeting

Let the person observe you and surroundings before anything is asked of them.

Formal intake has to wait until client feels comfortable with staff, environment and program.

The ability of workers not to make immediate demands, unless danger is involved contributes to relationship building. "Indoors, the clients get to watch you, and decide who they want to talk to, outside is different."

Hospital Settings

Greeting.

Introduction.

There are certain "givens" that are mutually accepted or we never see the client again.

An intake form is completed with the client that elicits basic information. Doesn't this impinge on relationship building? Sometimes it does. You have to keep in mind that when I'm called in, the person has been brought in by the ambulance, about to be hospitalized. They are seeing me in the early stages to make sure they have some place to go once discharged, and to strengthen skills of daily living to help them make it when they are out.

Workers need to be keenly aware of avoiding loud, abrasive, adversarial or intimidating behavior. Homeless mentally ill people seem to shy away from those who exhibit these traits with one exception, the loud worker who

incorporates the loudness into a personality type. For example, workers who speak loud with or without clients around. The worker's behavior is not a show for the client. It appears to be a part of their personality. Therefore, the client quickly realizes, regardless of pathology, that is how he/she is.

Ethnicity

Workers said homeless mentally ill people parallel people in society. If issues of race and ethnicity concern, affect and/or have affected them in a positive or adverse manner, or are paramount in their minds, workers should not expect that issues about the client's concerns about race will not disappear because one is homeless and mentally ill. If anything, the ego function of judgment which is already being interfered with, causes the negativity, insensitivity and harshness to present itself unmasked.

The negativity can be towards a worker of the same or different races, ethnic groups,

> ...I have seen clients here who come in saying, I don't want a black worker, because they don't work hard. The client is black. Or Jewish clients saying they don't want a Jewish worker, or black clients who only want a black worker. I've learned to expect anything and we try to be flexible....If you want it, we have it, and if it will help you, you have it. It still might not make a difference.

There was a client who would not talk to me because I was black. He spoke to other workers (white), overlooked me totally. He made it clear he has a brother who is a doctor

and a sister who is a lawyer, and he did not respect me. Worker was African-American.

It was not until I had to have him rehospitalized that he started speaking to me. This was hard.

There was a guy who was just totally obnoxious. I could not stand the kinds of things he did.... He would pretend he was blind, panhandle, then come to the..., and tell... how much money he made. Both of us were white. That did not enter into it for me. I just found him to be a ridiculous person. It may have been the psychopathology too.

Transference-Countertransference

Transference-countertransference issues are present and affect establishing relationships with homeless mentally ill people.

Workers expressed that it was easier to "work harder for clients you like," "clients who let you know they want, need and/or appreciate your help vs. those who act like they are doing you a favor."

Physical aggression towards workers, encroachment upon workers' personal space, sexism, racism, client psychopathology that incorporates the worker bode ill for a client becoming housed, unless there are workers, a system and program with the flexibility to transfer clients between workers.

> There was a client who insisted she knew me from...Anytime I approached her, she became loud, abusive, telling me details of how I gave her the injections at ...

> Logic fails in situations like this. This kind of behavior was disruptive to the program, other clients and my functioning. Luckily, this program and my supervisor allow for transfers between workers and clients...Again, I told the client I was not... but since I obviously remind her of..., she would get a new worker. All of this was done in the day room so that other clients could hear. They wanted to how she would be handled. Who knows if this will help this lady settle in...at least I tried.

The following section introduces additional issues workers and administrators found relevant in establishing relationships with homeless mentally ill people.

They addressed the following issues they felt played a part in establishing relationships with homeless mentally ill people: transference, countertransference, race, ethnicity, client psychopathology, the effect of agency resources.

Countertransference as a clinical issue is usually not the focus of discussion of homeless mentally ill people, at least not formally as countertransference. One can hear workers say, "She's a nice lady, I bet you like her," or "he's a rough customer, I'm not up for him, he's always nasty," "He's always crazy too." [Light laughter between co-workers.] "Listen, I'm not getting hurt because of anyone, forget it."

Countertransference

The concept of countertransference stems from Freudian psychoanalytic theory. Transference-countertransference classically is viewed as one type of phenomenon of resistance within the analytic situation. (Lang, 1981)

Transference is defined in several ways, however most of the definitions refer to a past experience being projected onto the present person.

> Transference may be said to be an attempt of the patient to revive and re-enact, in the analytic situation and in relation to the analyst, situations and fantasies of his childhood. Hence transference is a regressive process...develops inconsequence of the conditions of the analytic situation and analytic technique. (Sandler, 1981, p.38)

> Freud saw transference as predominantly a transfer of feelings about important objects from the past, to the person of the analyst in the present, and that they are experienced as real in the present. (Sandler, 1981, p. 38)

> Freud extended his notion of transference outside the analytic situation, and our social experiences, as well as our clinical experience with non-analytic types of therapy. (Sandler, 1981, p.39)

Ralph Greenson defines transference as the "experiencing of feelings, drives, attitudes, and defenses toward a person in the present which are inappropriate to that person and are a representation, a displacement of reactions originating in regard to significant persons of early childhood. I emphasize that for a reaction to be considered transference it must have two characteristics: It must be a repetition of the past and must be inappropriate to the present.

For the purpose of this project Freud's latter definition of transference, which he refers to the possibility of the phenomenon occurring outside of the analytic situation, and Greenson's definition of transference will be used. The exception in the latter definition is that the emotions the person experiences and projects onto the analyst, therapist,

helping person have not necessarily occurred in childhood, but at any time in the past.

The researcher defined and organized the material that was reported by the respondents as countertransference vs. client/worker attitude, since transference is a clinical phenomenon, while attitude is a concept that can be vague and nebulous. Three variables were used in organizing the data about transference:

1) experience outside of psycho-analytic situation
2) experience that has occurred in the past placed inappropriately on a person in the present (helping person).
3) the experience of the person has not necessarily occurred in childhood.

Given the above criteria workers and administrators said issues that facilitated or hindered establishing relationships with homeless mentally ill people are: the nature of the transference/countertransference, whether the client wants what program person has to offer (trust warmth, empathy, genuineness), whether the worker is able to provide (produce) contract services, and the attitude of worker toward the client.

A case could be established that the phenomenon the researcher observed is clients liking workers, workers liking clients, thus both taking a greater interest in each other. Client probability of following through with worker perceived

or suggested recommendation could be defined as attitude rather than transference-countertransference.

The issue of importance and effect of countertransference is what the researcher wants to add to existing literature on establishing relationships with homeless mentally ill people.

Literature seems always to point to:

1) resistant non-cooperative clients

2) effect of deinstitutionalization

The researcher wants to introduce the relationship issue and its effect on homeless mentally ill people. This perspective suggests that when the worker is aware of needed skills, procedures, pre-empathy phase of establishing relationships, and countertransference, the client may fare better in terms of receiving needed services, unless psychopathology interferes, to the extent that there is no movement until medication.

The relationship between workers and client/potential client is also a therapeutic relationship occurring outside of traditional psychiatric physical settings.

Attitude

A case could be made for the worker-client preference being labeled attitude vs. counter-transference as the latter occurs within the therapeutic boundaries of client and patient relationship. Since homeless mentally ill people are called patients only in hospital setting programs, and not called patients in any other setting, one could say what the re-

searcher is labeling counter-transference, worker responding more favorably to one client over another could be labeled attitude and not counter-transference.

A distinction is being made between counter-transference and attitude. Transference, counter-transference phenomena occur within the boundaries of a therapeutic relationship between therapist and patient/client.

For the purpose of this project, the definition of countertransference is addressed on page 105. Attitude is defined as a "learned predisposition to consistently react in a given manner (either positively or negatively to certain persons, objects or concepts.)" (Encyclopedia of Psychology p. 97)

The relationship between client/potential client and worker is not a casual relationship; it is a therapeutic relationship. The phenomenon workers describe, when based on past interactions with other people, not the client are labeled countertransference. In addition, countertransference is also being used for worker behavior which is not influenced by direct client-worker interaction.

For example, when a worker describes a client as obnoxious and offensive because he/she stands too close to the worker. This is viewed as worker attitude toward the client, based on something the client does/does not do.

On the contrary, when a worker states that a client reminds him/her of someone they knew once, this is being labeled countertransference by the researcher.

The researcher saw reported similarities in how workers and clients responses which would define the phenomena of worker preference as countertransference.

Namely, both workers and clients responded to each other based on past events projected onto the person of the present situation. Workers talked about some clients reminding them of themselves when they were that age or reminding them of "someone I knew once."

These kind of responses are categorized by the researcher more as countertransference as opposed to attitude. With the issue of attitude, it appeared a worker may have been more recently influenced by a recent event or interaction with the client.

Verbal and physical aggression toward the worker, and/or client demonstration of need for the worker influenced worker/client preference.

Responses to Critical Incidents

Workers were requested to speak about two incidents of their establishing relationships with clients. Not all respondents gave specific case material no matter how the request was phrased, rephrased, and examples given. The critical incidents were grouped into categories. Incidents were selected to illustrate the categories.

This section lists critical incidents that workers defined as going well and not going well. Incidents are grouped according to theme to illustrate what assisted or hindered workers in establishing relationships.

Some respondents could not/did not want to give specific case material.

One worker thought that the relationship building went well when the client could respond to his techniques.

> I don't think I work differently. My techniques (for establishing relationship with clients) are the same. The differences depend on the client. It really comes down to a matter of mix between self and client; are they responsive to me/any of my techniques. I have an array of techniques, pick from those, hopefully one that will work. I work better with people who have some capacity, any, for insight. I use humor, it can be concrete, directive. My success or failure depends on where the client is and his/her reaction to me.

She recounted an incident that did not go well.

> There was a client who had no capacity for insight/ retention of information, very anxious, tended to get fixated on issues. He would frequently say other clients see their workers whenever they want to, why can't I see you when I want to, a constant complainer, more concrete than I thought initially. He falls in love with white, blond women, does not have the capacity to learn from experience. I tried a loose approach. I started getting frustrated. He wanted to stop by anytime he wanted to (this is a hospital setting). I tried my array of tools...I found him annoying. He felt he could not talk to men. He was reassigned to a female counselor (my request). Her approach with him was more structured; she had a higher frustration tolerance level, yet she was still not effective.

Another worker recounted an incident in which countertransference was positive.

> Thinking of a guy, diagnosis of atypical psychosis, history of alcohol, no organicity, child-like, sexually involved with his father, gang raped...major trust

> issues. I spent 6 months or more working on basic trust, letting him talk about his past, non-directive. He disappeared for a year. When he came back he was ready for insight-oriented work. He wanted to make changes. We reviewed his past life, very supportive, got him into a Day program, gave him feedback, was reflective. He was very religious. I suggested that when he was upset, he should stop and read a few passages from the bible. He was also HIV positive. I was able to use his strengths, same ends, different means. I liked the guy...what worked with him would not work with all clients. I don't work well with clients I don't like.

One female worker reported working with a delusional client.

> There was a guy 33 years old, in the hospital from...He was paranoid, delusional, wouldn't work with me because of my connections with the KGB (I am Russian). I went to the unit twice a week, took him out for coffee. I did not think I had established a strong relationship with him, then he was transferred to...I did not see him for 6-7 months. He eloped from....for two weeks he came back to see me everyday. He was not nearly as stable as before, very delusional, having a hard time dealing with females. He came to see me. He was asking for help. I was really put off by his paranoia until I stopped getting involved in conversations about his delusions...pretty decent fellow. (Respondent female)

Workers were sometimes free to discuss their negative

feelings.

> There was a 35 year old woman, chronic, undifferentiated schizophrenic, hostile, brought in by the police. No one knew her real name. After discharge I got her a hotel room. I never felt close to her or felt our relationship was close. She would not follow up, was resistant. It was negative both ways. Then I found out she was pregnant and I had to get her re-hospitalized. It was not pleasant, because I had to trick her into coming into the lobby. The security guards were waiting for her. Needless to say, she does not trust me anymore. The counter-transference from me isn't good either, because she presents herself as someone who does not need help...she's doing you a favor.
>
> There was a client whom I felt intimidated by. He does not like women...told me he hated women. He had this air about him that he's better than you. What can you do for me? He won't look at me. I don't take him anywhere...I do my job, nothing extra.

One worker described how she responded positively to the client's need.

> There's a client who told me after I introduced myself, and my purpose, I need you, I've been homeless for 18 years. She expects immediate help, sensed right away that I would try to help her. It worked out where I did find her a place right away. She was smelly. I had to ask her to please take a shower before we saw each other again. I spend so much time with her; treat her like she's a baby...she's 29, can't make up a bed. She needed me and said it, I responded.

Mutual distrust characterized some exchanges.

> There's a client who doesn't trust me. He looks at me like I'm Oriental. He believes that I'm dealing drugs. He's black, delusional...it's the way he looks at me It's uncomfortable, scary. It has taken four sessions of my trying to be friendly, show some concern, just for me to feel slightly comfortable. He still says...I don't want you here, what is your purpose? We are on shaky territory.

In another instance, the client's prejudice was a barrier to establishing a relationship.

> There was a client who saw me and said he did not want a black worker...he was prejudiced against black people -- all of them. I told him that I understand that you resent black people, but I need you to work with me for you; he started to distance himself from me; discharged then re-hospitalized. I wanted him to deal with this issue, confrontation. He refused treatment. The thing that stopped the relationship is that he was prejudiced and I gave him space...maybe too much.

In this case, mutual interest and racial congruity supported the relationship.

> This client was not mine at first. She was transferred to me. She was catatonic, would not eat or talk to people for a year. Once I started visiting her on a regular basis, her behavior improved. Most of the people working with her previously were not African-American. She was a former opera singer. When Sarah Vaughn died, it hurt her a lot. She came to me. She realized we had an interest of the heart. Basically, I was observant, saw that she was interested in music. We would have lengthy discussions about music, which led to what she had done before. No one used this avenue previously.

Negative countertransference was evident in some responses, although it was not always acknowledged.

> I cannot work well with all of my clients, if I don't like them. There was a man with layers of pathology. He would not follow through on any plans. Medication did not help. I saw him at what doctors thought was his baseline. He came too close to me, huge guy, overweight. He had no concept of personal space. He would call and look for me constantly, yet I was not connected to him in any positive way.

A difficult beginning can hinder the development of the relationship.

> I just started here doing a pre-screening when I described the program as 'we help homeless schizophrenics.' The person told me he wasn't eligible. It was just too much reality for our first meeting...it depends on the client most of the time, you get one shot, make it good...it makes it harder.

Client insight sometimes created a positive relationship.

> Yesterday a client opened up to me. We only talked previously two times...he trusted me, even though I had him admitted to psychiatric emergency. He trusted me after that, no anger, no resentment...He realized he was doing much better after that. He had some insight, felt comfortable around me. He was not very intelligent. He could see that he was doing better than before.

Client psychopathology may affect the length of time it takes to form a relationship.

> There was a client from California, borderline personality, most difficult to work with, disdainful of programs. In terms of our relationship, I feel I did not have the skills to deal with him/engage him in idle chit-chat. I tried to encourage him, he left after three months...did not connect with anyone here. It takes a while...they don't trust you right away, why should they? Most have been socially isolated, it's up to you not to push them, be pleasant, gentle. Eventually most will become connected, develop some sense of trust. You need to follow through.

Prejudice is evident in many of the client's responses.

> There was a manic depressive, white client that would pass by me (worker African American) and go to other staff. They would redirect him to me. He had a brother who was a doctor and a sister who was a lawyer. He had a lot of resentment. I remember him well. He refused medication. I had to have him re-hospitalized. After the second hospitalization, he realized I had some authority. A long while after, he apologized. There was definitely an issue of ethnicity and authority. He was rich and did not see me as an authority figure. This was a difficult time. I kept thinking about situations that I have encountered previously, that were handled. I have a great supervisor. He's a good person.

The worker's values often give purpose to the relationship.

> I came in October last year (not in this position). I was head nurse on the critical care unit. One of the things that concerned me most when I got here was, why the men had to be so dirty and smelly. My first bizarre incident, was with a man who was dirty and smelly. I approached one of the clients who was dirty and smelly. He seemed high functioning; cared about his chores. I asked him why he was so dirty. His response was that nobody ever asked me that question before. He had been in this system for 10 years and no one zeroed in on his appearance/hygiene.
>
> Homelessness and mental illness do not go hand in hand. I worked with him around his hygiene. All a person needs is two changes of clothes, wash one set while wearing the other. I got the laundry schedule (in the shelter), he started taking showers, established "project clean workshops"; we've been consistently meeting on Fridays. The individual that I first approached, changed his hygiene habits, and now helps others. "Project clean" works on body cleanliness, mind cleanliness, cooking workshops, trying to prepare clients for the community. Society as a whole accepts a dirty homeless mentally ill person, never questions. Poverty exists, but ethics and cleanliness go along with it..In.., we have a lot of extreme poverty, but people have two uniforms; wash one, wear the other.
>
> Homeless people can get clothes from the Salvation Army. I have had many positive relationships...as the relationship develops, the person can change in behavior, have better self-esteem and self-image.

Workers need to learn to take client pathology into account.

> I started here about one month ago. I met a woman in the park. She took to me...very paranoid; said she was working for the police. I pushed too fast for someone who is paranoid...should have moved slower, give more space. I asked too much too soon. I asked her name, before she was ready. I have not seen her again.

Bad start

> I saw a man on the street. He was innocent looking. I was advised that he was mentally ill. I didn't get in front of him. I approached him from the side. He had a shopping bag, and swung it around to hit me. I should have been in front of him, instead I was shoulder to shoulder with him. I encroached on his space. I had to run away from him.

Transference/countertransference - client's need.

> Most [relationships] have gone well. I went to interview a client. The worker met me. There was a psychotic man, in and out of the hospital, many years homeless. We hit it off right away. He stuffed newspapers in his clothes to make it look as if he had huge muscles. I explained who I was and what I could do...arranged transport for him, had him evaluated for medication. The sad part is once he was on medication he lost his sense of humor. (What made the relationship work?) I did not come off as he expected. I laughed with him. When I said I was from ...he wanted to come to...to get out of...He wanted something I had to offer and he didn't expect me. He was a funny guy...I liked him.

In response to critical incidents concerning efficacy of relationships, workers and administrators identified eleven variables which contributed to relationships going well or not going well. The variables are: transference/countertransference, timing, the manner in which you approach people, client trust (of worker), worker ability to listen, rapport building, worker ability to accept rejection, starting where the client is. Workers readily explained that for them this did not mean total acceptance of client's psychopathology just..."If a client has been on the street for years, no

regular food, decent shelter, the worker does not talk medication until concrete needs are met and the client is comfortable with the worker," going at client's pace, worker ability to think through steps/procedures without losing spontaneity, client's need (client wants something you have), and timing. The chart below illustrates the number of responses in each category.

Practice Principles

1. Worker needs to know what one is doing before varying an approach, theory or technique.

2. Workers being aware that trans-ference-counter trans-ference issues can help or hinder in the relationship process helps make appropriate use of limited resources.

3. There are steps and procedures in establishing relationships with homeless mentally ill people. Although not performed in a perfunctory (routine) manner, the same steps, procedures are included in each setting, in addition to the worker's ability to show genuineness, warmth and empathy.

On Minority Homeless

Race and Red Herrings

Polarization and conflict occur when the topic of racism is introduced in discussion of homelessness. Race and ethnicity may have nothing to do with homelessness. However, the phrase "over-represented" is frequently used in the literature when referring to minority homeless people. Some interpretations of the phrase are:

Table 16

CRITICAL INCIDENTS CHART

This chart illustrates the categories that critical incidents were grouped in.

Category of Response	Number
Transference/countertransference	12
Client trust of worker	13
Rapport building	5
Client need	4
Start where client is	3
Timing	2
How you approach people	1
Ability to accept rejection	1
Go at client's pace	2
Steps/procedures	1
Two respondents were not asked.	
Total	40

This total is reflective of workers and some administrators still involved in direct service to clients.

- Homeless people are predominantly minority group members.
- Although African American and Hispanics represent 12.2% and 8% of the population respectively, African Americans represent much larger percentages of the homeless population in urban areas.
- In urban US cities especially New York, Chicago, Los Angeles, African Americans represent 53-70% of the homeless population.
- The African Americans who use public shelters tend to be younger, unskilled high school drop-outs and some with high school diplomas/equivalency.

African Americans and Urban Areas

African Americans are clustered in urban areas. During the 19th century one half to 90% of African Americans lived in the southern section of the United States (Harvard Encyclopedia of Ethnic Groups, 1980, p. 6). Today approximately three quarters of African Americans live in urban areas. "The black presence has been troublesome and a critical one, posing a continuous paradox at the heart of American rationality" (Encyclopedia of Ethnic Groups, 1980, p. 6).

The peculiar relationship continues, and perhaps may contribute to why solutions and aid are not as quick and concise as they could be.

Perhaps more has not been accomplished toward achieving a better quality of life for mentally ill homeless people, as

they are now equated with unhelpable causes, mental illness, African Americans and poverty.

Ethnicity

Most workers could not give percentages of their cases according to ethnicity, because of lack of time, interest to calculate or its relative irrelevancy to what they were required to do. All workers when asked to rank order their clients according to ethnicity said: Black 1st, Hispanic 2nd, and White 3rd. The former two groups were dependent on the setting. Asian people had a very small percentage. Some workers separated African Americans from Caribbean Islanders, grouping the latter group as other. There were other workers who categorized people from other European countries and/or the Philippines as other.

Out of the eight administrators interviewed, one was black, seven were white and two Hispanic.

The following were responses of the worker to the question, does the ethnicity of the worker providing service make any difference to the client population.

In general workers spoke to the need for a range ethnicity of workers because clients tend to mirror society and have the same preferences as other society members. The fact that they are homeless and mentally ill does not make them more humble or tolerant. If anything, the mental illness tends not to keep prejudices in check and clients are "right out there with their prejudices, preferences, likes and dislikes."

Table 17

WORKER RESPONSES TO THE QUESTION,
DOES THE ETHNICITY OF THE WORKER PROVIDING SERVICE MAKE ANY DIFFERENCE TO THE CLIENT POPULATION

Yes	13
No	08
Sometimes	12
Other	01
Not Asked	06
Total	40**

**This total is not reflective of sample size, as two respondents were not asked due to time constraints. The other missing response was because one respondent felt adamant that the question should not be in the study.

Listed below are some responses from workers on this issue.

- Sometimes the worker ethnicity makes a difference. Sometimes the person relates to you better if you are their preference (ethnicity).

- Definitely (worker ethnicity makes a difference). That's why we're pretty lenient. The client can have preferences around ethnicity and gender. We try to match them up. It comes through experiences living on the street.

- Very much, that's a whole chapter in itself.

- It hasn't so far, but I think it could. I don't think it has to.

Ethnicity Worker Perspective

Workers and administrators voiced that issues around race, racism and ethnicity are present in relationships with homeless mentally ill people. However, the degree of involvement with any of these issues depends on the client and worker. Both workers and administrators stress the importance of having a mixed staff in terms of race, ethnicity and gender because people have preferences, homeless or not. The mixture of staff provides a wider possibility of people who are homeless and mentally ill to cathect to regardless of their preference.

Some workers also cautioned that regardless of how many combinations of workers there are, some clients who will not connect with anyone in the present program and may/may not connect with another worker and program later on. They felt this had to do with the issue of repetition. The person/client has heard the same thing so many times stated

various ways that one day it may come together for him/her, and produce the needed effect.

In an administration masters' level social work class lecture (Fall semester, 1989) that the researcher attended, Ralph Dickerson, Executive Director of the United Way said people give to causes they feel they can help. In addition, an article was shared which supported this thesis. Perhaps ethnicity is not as much of an issue as the combination of issues that people feel cannot be helped (Guy, 1987, p. 1).

Table 18

WORKER ETHNICITY TABLE

This table illustrates the ethnicity of workers participating in the project.

Ethnicity	Number	Percentage
White	26	62
Black	11	26
Hispanic	04	10
Philippine	01	02
Total	42	100%

ADMINISTRATOR ETHNICITY TABLE

Administrator	# of Administrators
Hispanic	01
Black	01
White	07
Total	09

Chapter 5

SUMMARY OF FINDINGS

The findings of the project are presented in relationship to the variables studied.

Programs

This project included a purposeful sampling of programs that provide services to homeless mentally ill people. The project focused on how workers within the different programs establish relationships with homeless mentally ill people.

Program quality control was established by including for study only Community Support Systems (CSS) programs. A range of programs were incorporated to explore the possibility of variability within ways relationships may or may not be established.

On Relationships

Workers addressed the importance of establishing a relationship as crucial to their work with mentally ill homeless people, 40 out of 42 (two workers not asked), or 95% estimate that they spend 50% of their time on establishing relationships, then once established, maintaining relationships with homeless mentally ill people.

Findings

- Steps/procedures are involved in establishing a relationship with a homeless mentally ill person. The steps are not necessarily in a particular order, however, they are usually always present.

Introduce self and program; be able to state name (first name), and introduce the program, what it can do for the person clearly, succinctly, be aware of approach, boundaries, consistency.

- Issues of race/ethnicity are present in establishing relationships with homeless, mentally ill people, but the degree of involvement is dependent upon client and/or worker responses.
- The issues identified by Truax and Carkhuff (1972) as essential in establishing positive relationships are present in establishing relationships with homeless mentally ill people in addition to ability to make accurate assessments, flexibility and creativity.
- The steps/procedures in establishing a relationship with a homeless mentally ill person are: Observation (when possible to see what the person likes/dislikes, interests) all in an effort to engage the person in conversation, assisting with the assessment.
- Be aware of and know how to deal with transference/ countertransference issues as they present themselves.
- Because of the proliferation of drugs and/or alcohol in our society, a worker needs to be able to tell the difference between symptoms of mental illness and alcohol/substance use.

- Be able to recognize the major diagnoses of Axis I of the DSM III R, particularly schizophrenia, major affective disorders, personality disorders.
- Workers have to listen to what clients say they want, start there, while setting and attempting to reach realistic goals.

Education

Forty out of forty-two workers, 95% felt that the education of the worker providing service is not crucial to the process of establishing a relationship.

Education assists workers in being creative in thinking, however the education of the worker does not necessarily communicate worker warmth, genuineness, empathy, ability to produce results.

Workers were definitive: 42 out of 42 or 100% expressed that education of the worker helps "with report writing," verbal and written communication with peers, referral sources. As one worker openly expressed it, "...I can get them (clients) in here, help them stay...when it comes time to write anything, I freeze or need help. They (the agency) would not send me anywhere to represent them, but I can get clients to come here, to try to get help."

Knowledge

Forty-two out of forty-two (100%) agreed on two areas of knowledge needed to perform their jobs, and to establish and maintain relationships with homeless mentally ill people:

1. Working knowledge of the DSM III R, in particular the diagnostic categories of schizophrenia, bi-polar disorder, depression, when possible ability to recognize and work with individuals with the dual diagnoses of mental illness and substance abuse.

2. Basic counseling, interviewing, social work skills (contracting), along with knowing when to use all of the above (timing).

Workers also emphasized that the above knowledge aids in not personalizing interactions with clients: e.g., people with delusions, using denial as a defense mechanism, what to do when someone is experiencing auditory hallucinations. One needs to know how to respond to someone who uses denial as a defense mechanism and how to respond when someone is experiencing auditory hallucinations.

Workers also said that even with the knowledge there are those clients you will not be able to reach "...know it, understand it, and be prepared to move on."

Skills

Workers emphasized that the skills needed to establish relationships with homeless mentally ill people are empathy, patience, consistence, creativity.

Steps and Procedures

Workers said they did not easily conceptualize the steps and procedures in establishing relationships with homeless mentally ill people consciously, and they did not approach

anyone in a perfunctory or routine manner. Yet the researcher observed, heard the same components from workers in trying to establish relationships with homeless mentally ill people even with program variability.

Differences in steps and procedures were more prominent when programs had or used particular protocols, due to their setting.

The steps and procedures usually included:

1. Worker observation of potential client when possible to see what can be used for assessment purposes, initiate and maintain conversation.

2. Greeting

3. Introduction of self, purpose and program.

4. Period of waiting, mutual assessment while worker demonstrates consistency, genuineness, warmth, caring to prospective client. This appeared to be a period where the worker performs a delicate dance of availability, consistency, persistence.

5. Contracting, outlining client needs/wants with the reality of worker, program ability.

6. Movement towards goal attainment.

Program Differences

Some of the programs' steps and procedures included an engagement tool and/or initial protocol which had to be completed by the worker. These protocols incorporated the same six steps listed above.

Establishing Relationships

What are the factors that cause a relationship to go well with a homeless mentally ill person? According to workers and administrators the most important factors which contribute to a relationship going well between worker and client in their programs are: 1) the client wants/needs something that the program has/can provide. This includes the ability of the worker being warm, trusting, genuine; "trust is the thing"; 2) positive transference (client) countertransference (worker); 3) worker's ability to look, listen and act upon an opening/opportunity to show interest, caring, willingness to do something extra; 4) clients' capacity for insight, however slight. "When they can see results, this makes a difference in the relationship;" 5) having respect for the person, not as a stigmatized entity; 6) knowing how to distinguish between worker aggressiveness, assertiveness, how to modulate both; 7) worker non-acceptance of prejudices, openness, willingness to change, challenge, be creative, 8) worker consistency, ability to follow through; 9) worker ability to accept rejection; 10) worker ability not to demand what is not offered to you. This applies to client's name, space, articles, e.g., in street outreach, workers made a point of saying, "walk up to the person, say your first name only."

In working with homeless mentally ill people most programs try to cater to client wishes/concerns, while balancing program demands. For example, in a traditional

setting, if a patient/client requests another worker, the client and worker might be requested to try and work through/resolve the transference/countertransference issues. This could involve a substantial amount of time. In settings working with homeless mentally ill people, they try to have a mixture of workers/personalities that clients can cathect to. They will accommodate clients and workers by transferring them without a lengthy evaluation and introspection period. Workers and administrators stressed the necessity for worker mix, gender, ethnically, racially, personality/style.

Traditional vs. Adaptation/Improvisation

Establishment of relationships in social work generally involves some givens; depending on the setting.

1. Appointments are made with a client.

2. An intake is done as quickly as possible.

3. One makes an effort to be warm, however there is usually no pressing need to sell the service/worker to the client, as usually the client is seeking help, has enough insight to know he/she needs it. There are exceptions to the above as with clients remanded for treatment and other settings, however the worker for the homeless mentally ill appears to have to work harder at proving his/her usefulness.

4. The worker is usually able to convey a sense of program boundaries/limitations during the first meeting.

5. The worker is careful not to offend/be over solicitous of the client.

With homeless mentally ill clients the differences in establishing relationships are:

1. Appointments are not made initially, workers make an effort to be in the same place at around the same time daily (particularly with street outreach) in other programs, there may/may not be specific times for activities; however, the emphasis is on getting the person to come first, then closer to or at a particular time. As the person may have trouble with time, may not have a watch, have to complete other activities prior to social service involvement which affects their daily living.

2. An intake is not done initially in the street/day program/shelter or drop-in work with homeless mentally ill people. Residential and hospital settings vary on the timing of intake interviews.

3. In all settings workers make an effort to quickly explain the services, how they can/cannot be helpful, "to sell" the program.

4. Emphasis is not placed on program boundaries/ limitations initially; an attempt is made to use anything and everything to "hook," engage the person in depending on program/agency philosophy. Some programs are voluntary, and feel that clients must make their choice to participate, or the treatment will not work.

5. The worker may/may not do unconventional things depending on experience, personal style and according to the

situation. Humor is used liberally, depending on the worker's ability to use this as a medium of connection. For example, the worker/administrator who laughed with the man with paper stuffed in his clothes appears unorthodox, however she felt that the worker's laughing with the client helped to facilitate the establishment of a firm relationship.

There appears to be more similarities than differences in working with homeless mentally ill people, and any other client group. The exception is the most obvious, issues of cleanliness, in some situations, odors and sheer frustration in working against odds with limited resources.

The same skills needed to engage and establish relationships with other client groups are needed with homeless mentally ill people.

Table 19 illustrates some of the similarities and differences in establishing relationships with homeless mentally ill clients vs. any other client population.

Table 19

SIMILARITIES AND DIFFERENCES CHART

Similarities and differences in establishing relationships with homeless mentally ill people vs. any other client population are outlined in the table below.

Similarities	Differences
1. Greeting	1. With issues of transference/ countertransference with homeless mentally ill people there is no time, manpower, or energy for workers to work through transference/counter-transference in supervision; if a client expresses an inability to work with an assigned worker, the client is usually changed to another worker if possible. Most programs have a variety of personality, people types for clients to respond to. This addressed client preference such that it cannot be used as resistance from working on needed goals.
2. Components necessary to positive relationships are: warmth, genuineness vs. empathy.	2. The worker may only have one meeting if person's psychopathology interferes. Worker movement (direct/indirect) can contribute to client's flight.
3. Need for proper assessment	3. The worker appears to initially try to demonstrate his/her usefulness.
4. The more skilled on is in techniques of engagement, the greater the possibility of establishing a relationship barring the depth and type of client psychopathology.	
5. The first meeting gives an impression of you. Sets stage for further encounters.	
6. The worker is trying to appear competent, caring.	
7. The agency function contributes to the establishment of a relationship.	
8. Assessment	
9. Contracting	

Chapter 6

DISCUSSION AND RECOMMENDATIONS

This chapter summarizes the project and presents implications for policy and practice. Issues beyond the scope of the study are introduced.

In this descriptive exploratory study, 42 workers and 9 administrators from 10 different programs serving homeless mentally ill people were interviewed for the purpose of ascertaining how they specifically establish relationships with homeless mentally ill people. This information was compiled and analyzed with recommendations for a workshop for service providers interested in service delivery to this subgroup of the homeless population.

The relevance of education, knowledge, skill, steps and procedures, race and ethnicity in establishing relationships with homeless mentally ill people were explored.

Workers and administrators felt that workers' education was not a crucial variable in establishing relationships with homeless mentally ill people. Workers said education definitely helped with report writing and communication--written and verbal--with agencies. "Education impresses one's colleagues...clients want to see results."

However, workers also said some of the educated workers (credentials, length of schooling) were more creative with ways to engage, establish relationships with clients or potential clients.

There was a difference in what the researcher observed and what respondents said about the relevance of education and establishing a relationship with homeless mentally ill person.

Workers and some administrators said education was not as crucial to the process of establishing a relationship. Education helped with correspondence, communication (written and verbal), but, clients seemed more impressed by results.

Interestingly, the researcher observed that it was the more educated worker in terms of knowledge who was able to make quicker and more accurate assessments. The workers knew which client could utilize agency resources best and were most professional in their ability not to personalize client's negative attitudes toward them.

Perhaps workers stereotyped the educated worker as being unable to relate, perhaps not. Yet, workers clearly said it appeared that the more educated workers were more creative in finding ways to establish a relationship with a client.

Workers said education was not crucial to the process, however, educated workers appeared to think of more creative ideas to get someone interested in what they (the program) was offering.

An artificial distinction was made to respondents between knowledge and skills. Knowledge was defined as information one obtained from a book, article, class workshop setting and skill was defined as something workers do. The knowledge needed to establish relationships with homeless mentally ill

people is a working understanding of the DSM III R, some understanding of the diagnostic categories of schizophrenia, depression, alcohol, substance use and possible differentiation between the latter two diagnostic categories.

Some of the skills needed to establish relationships with homeless mentally ill people are: assessment, contracting, patience, persistence, crisis intervention.

There are steps and procedures involved in establishing relationships with homeless mentally ill people. Although the steps and procedures may vary slightly according to agency protocol, however, generally include: observation, when possible to see what can be used for assessment purposes, issues that a worker can talk to a client about and/or keep a conversation going.

Issues of race and ethnicity do not take a holiday because someone is homeless and mentally ill. Workers should know and expect to deal with a client and their issues around race and ethnicity. Most programs handle this by having a variety of workers (ethnically, racially, and personality-type wise) to address client preference.

When client psychopathology is so ingrained and perversive, the issue of establishing a relationship becomes moot, as there is no movement with this client until he/she takes medication. Workers need to be aware of this, accept it, and be prepared to move on to the next needy person.

Additional issues were raised that were not in the purview of this study, thus were not explored in detail. Namely, any worker who plans to work with this client population needs to understand that they may not see or work with the same client from the beginning of the process to the end. They may not see a client housed or on medication. This process may take a series of workers, each saying a similar message to the client before he/she (client) shows any movement. One has to have a personality type that can accept and acknowledge this. (Not seeing the final stage.)

The lack of a unified federal policy on homeless people makes it harder on workers to know about and make connections with the existing limited resources.

Homeless mentally ill people want help. Some feel so discarded by our society that it is incumbent on workers to know how to connect with, establish a relationship with and prove that they are trustworthy, prior to a person receiving the needed services. Study findings indicate that the workers who are more successful in establishing relationships with homeless mentally ill people have a plan of how to approach the person.

This chapter further elucidates findings, and addresses relevant concerns beyond the scope of the study. Issues addressed are: worker characteristics, functionalism theory, education, creativity, impact of no unified policy, race-

racism, relationships and situations where relationships are moot, efforts toward solutions.

Worker Characteristics

There are issues workers, and potential workers, homeless mentally ill people need to know abut themselves, situations that may present themselves about homeless mentally ill people and how they (workers) might respond. For example, the tension level is understandably high in working with homeless mentally ill people. The homeless mentally ill person must contend with where his/her next meal is coming from, being cold, possibly physically ill, not adequately being clothed, and emotional illness. The possibility of arguments and/or fights, disagreements between clients, client and worker is a reality. An example of what the worker must deal with follows:

One morning, the researcher arrived at a site early. Two men, later identified as clients were engaged in a physical fight. An agency worker came from inside, broke the fight up, made an assessment of which client should come into the program and which one needed more time to "cool off," (directing him elsewhere). When the worker finished, he was perspiring. Later, when the researcher was introduced to him, he said "now you see how I have to start some days."

The worker and researcher chatted briefly about the frequency of such an incident occurring and the worker made it

clear that while this type of incident does not occur daily, he has to be attuned to who his clients are and what kind of interaction is occurring between them, as physical confrontations are inevitable.

The researcher observed that the worker was quick, non-hesitant and obviously confident enough in himself and his skills, as he did not go to anyone else and seek direction, he responded.

Crisis intervention techniques are used to diffuse potentially dangerous situations, however when all techniques fail, workers have to be prepared or recognize that they will have to take action that in their opinion is appropriate to the situation, taking into account themselves, the client and the environment.

In another situation what could have escalated to a more intense physical confrontation, a worker describes what she later identified as an improper approach to a client. She approached an already identified mentally ill person from the side. The potential client could not see who she was (full picture), only saw someone or something from his peripheral vision coming into his personal space. The client swung around with a bag already in his hand to hit the worker. The worker made an immediate assessment to run, not explain who she was, her purpose.

Workers frequently talked about the fact that they are not always able to personally see the client reach the goals

that they have set such as the client being stabilized on medication or being housed. Workers thought that anyone who is contemplating the provision of service to homeless mentally ill people should know that they are a part of a process. It may take a sequence of workers over time, each communicating a similar message prior to a client making steps toward a goal that is beneficial to him or he, if it happens at all. The on again, off again role of the worker in the process seems to be second to the role and function of the agency at times.

This is a paradox, for sometimes it is the worker who attracts the client to the agency and/or keeps the client in the program. Yet, at other times clearly, workers have to accept that the agency and the services it provides are more important. Through the input of a sequence of workers and a sequence of programs, some clients make the needed modifications to acquire needed resources. Functionalism may elucidate this seeming puzzle.

Functionalism

Functionalism is a social work theory which originated in the 1930's in direct opposition to the influence of Freudian psychoanalytic theory on the social work profession. (Yelaja, 1986) It departed from the diagnostic model and developed separate principles which may assist in addressing what the researcher saw and heard from workers.

Yelaja, (1986) outlines five principles of functionalism in his article on functionalism and social work: 1) the

client participates in the diagnostic process, 2) use of time phases, beginning, middle, end of service, 3) relationship of agency purpose to structure; what and how social work services will be delivered, 4) the use of worker-client relationship to involve the client in deciding what service he/she needs, 5) the function of the agency determines how and if services are delivered. (Yelaja, 1986, p. 161).

The most distinguishing feature which can aid in bridging the gap in work with homeless mentally people and theory is the importance of the agency function and the services it could provide.

Although workers did not say this, it was the researchers opinion that workers understood that the agency services were more important to the client than they were as individuals.

Creativity

It is the worker's opinion that essentially creativity was needed to respond to an atypical client group, presenting atypical needs, creative workers respond with atypical methods to get the client connected. This was one definition of creativity. Innovation was another. For example, one worker who used a cat to communicate with an unresponsive, non-verbal client was considered creative.

"A client came in who would not talk to anyone. We have a cat that stays behind the piano. She started taking an interest in the cat, asked was I feeding the cat enough,

because it looked so thin. From this point, we talked about the cat rather than other issues."

In another instance, a worker used music tapes and the death of a well known performer to share feelings of sorrow, mutual affinity to music and subsequently more conversation, stronger relationship between client and worker.

Another worker clearly did more than the job required in helping a client locate family members by going to the client's old neighborhood to locate relatives. Once the worker located the client's relatives, the client knew (despite psychopathology) that this worker did something out of the ordinary.

The above situations may be less likely to occur in a traditional office setting with clients/patients.

When Issues of Relationships Become Moot

There are times when regardless of worker skill, knowledge education, personality, race, workers are unable to establish a relationship with a homeless mentally ill client. The issue of establishing a relationship is (superfluous) moot, when the client's psychopathology is so entrenched and pervasive such that a client's particular delusional system is impenetrable without medication; the relationship issue becomes impossible. These clients may do better at a different time or with a different worker.

Impact of No Unified Policy

The impact of no unified policy for homeless people addresses the lack of congruence between society and a growing segment of our citizenry that has been left to fend for itself with no appropriate tools. There is a scarcity of affordable, low income housing, it's rare to find the singe room occupancy hotel where one could get a room for a night reasonably.

The lack of a unified policy contributes to the lack of resources, client frustration and homelessness. The worker's frustration is in knowing well what a client needs, yet being unable to supply or connect the client to the service.

Race, Racism

It is the worker's opinion that race and racism have an impact on homelessness and particularly homeless mentally ill people.

Unfortunately, the mentally ill are already stigmatized. When issues of race are added, the results is a disenfranchised group of people who watch as society delivers the message that they are not as important as ammunition, war, space equipment or savings and loan banks. It is okay to eat from the garbage, use the bathroom anywhere you can, be sick, or even die on the street.

Eventually, one might question, are the medical illnesses of some homeless mentally ill contributing to all of society's ill health? If you are mentally ill, eating from garbage containers, riding the subway and have untreated tuberculosis,

does the continued illness, contribute to the spread of disease?

A homeless mentally ill person is less likely to walk into an emergency room, be processed through triage then wait for treatment.

Impact of Worker's Attitude

Frequently, we hear about the resistant client, however, several workers introduced the issue of client likability. Some clients appeared to receive access to services more easily due to positive worker attitude, toward them, workers favoring one client over another. Workers' attitudes are sometimes influenced by how the client presents him/herself, needing, wanting help, being non-adversarial. This is an issue which needs further exploration. This issue may point to a model which encourages workers to explore their part in clients receiving services.

Suggestions Towards Solutions

Several issues presented themselves through this study as suggestions toward solutions, namely:

There is a need for a unified homeless policy. Many people would not be on the street if we had a federal policy which encompassed all homeless people.

A set of mobile medical vans with hospital back-up would assist in treating homeless mentally ill people for a myriad of health problems, which may or may not be contagious. Yet, it still begs the question, is this the quality of life we

want for our citizens. A national health insurance policy could only help further.

Strategically placed portable toilet facilities would help with homeless mentally ill people sharing in a quality of life that is higher than an animal.

Employment opportunities can assist all homeless. Some homeless mentally ill people are able to work and would feel more productive if they worked.

Listed are some offers for solutions for amelioration of the problem until the mental health system decides on a more appropriate policy than allowing the emotionally ill to meander in the streets, hurt themselves or someone else prior to help or hospitalization.

Mental Health

Every identified mentally ill person that comes in contact with the city/state has an assigned case worker. Private agencies can actively locate those mentally ill people who have not come through agencies. (Outreach)

Every psychiatrist donates 1-2 hours to a homeless program for psychiatric support, medication evaluations and prescriptions.

The psychiatric community should state clearly that it cannot cure schizophrenia; amelioration of some of the symptoms is possible. Our options are currently institution-alization, provide community treatment follow-up or let people continue to live in the street.

Exchange

Perhaps there should be an exchange for shelter. Clean, safe shelter is available for everyone in exchange for meaningful work which leads to employment paying the minimum needed to rent an apartment.

Religion

Every church/synagogue in the city can provide some service for homeless people; food pantry, soup kitchen, temporary and/or permanent housing. In exchange those churches synagogues get special recognition by the mayor's office and/or media.

Politics

Social workers need to lobby for a federal policy on homelessness; come together on how the problem is defined, lobby to get the federal government back into the housing business and/or to delineate a clear policy for homeless people.

Tax incentives to realtors who build housing for low to moderate income housing would probably assist with the paucity of housing.

The media, although here to make money, can question its moral position and start questioning stories that only speak of gloom and doom.

Chapter 7

CONCLUSION

This chapter summarizes and presents the conclusion of this project.

Homelessness

Homelessness has been a part of the American tapestry since the pilgrims founded the thirteen colonies. No one coming from England to America had homes.

Society's response to people without homes continues to vacillate between provision of emergency, baseline assistance, residual policy, to get and keep them out of my sight, to there is something morally wrong with this type of person. Others acknowledge the deserving and undeserving poor, and offer that one should help the deserving poor, but not next to or around me...the preference is to keep them out of sight and confined together.

Mentally Ill Homeless People

There is no cure, no panacea to date, for schizophrenia. If one follows the principle of thirds, one third get better with no intervention, one third remain the same, even with intervention, and one third get worse. We are faced with the reality of what is humane appropriate care for the 1/3 that does not get better, perhaps worse.

Bassuk seems to give an answer to the question clearly and eloquently when she states, "Some will need continued care" (Bassuk, 1984, p. 45).

Other mentally ill people can survive, live decently and with dignity if they had access to resources. Resources (programs, permanent housing) are in small supply. For example, in the city of New York, there are an estimated 90,000 mentally ill people, based on psychiatric hospitalizations only (Dept. of Mental Health, Mental Retardation and Substance Abuse, Feb. 1990). Of those who are discharged on their own recognizance, everyone knows that once the medication stops the symptomatology that brought the person to the hospital starts anew and life goes on, until someone gets injured or dies as a result of an interaction with another person whose ego functions of reality testing and judgment are riding in the wind.

Homelessness increases and decreases depending upon the economy, policy and the public. The current extent of homelessness is due to: public policy decisions of the Reagan Era, mental health policy, deinstitutionalization, and psychiatric hospitalization policy, lack of affordable housing, poverty. Drugs and alcohol also are in the picture, the extent and order continue to be debated.

Mentally Ill Homeless People

We have moved from the snake pit indoors to the snake pit outdoors.

Some of the people living on the street clearly cannot take care of themselves, still others are walking motion bombs, waiting for the unfortunate soul to make the wrong

motion, be in the same place at the same time and the person gets hurt, injured and/or killed. Let's not delude ourselves, some of the homeless mentally ill need a hospital, continued care and/or continued monitoring, while others even though "eccentric" can add their eccentricity to society without major concern, fear or alarm.

Toward Conclusions, Reasons, Rationale

Homeless mentally ill people, like all people, need affordable permanent housing. Meeting this need requires federal intervention, in the form of a policy which states how homeless people will be treated.

The period of "outrageous excess" associated with former President Ronald Reagan made some feel as if they were watching a movie. When one is watching a movie, you do not want interruptions, particularly interruptions like poverty, homeless people, mentally ill homeless people.

Unfortunately, some of what we are witnessing now in reference to the increase of homeless people is a direct relationship to the "outrageous excess" era of the Reagan presidency period. Lavish spending, program cuts were fine then, now we pay. The "trickle down" theory becomes the yeast principle (left undisturbed, the dough doubles in mass). None of the wealth trickled down to the lower echelon, only increased in mass at the top. The wealthier maintained and increased their wealth, while the disenfranchised remained so and got worse due to the recession.

The Republican administration made cuts in social service programs, aid to families with dependent children, and the social security system, and we are now confronting the people who fell through the safety net hole.

In addition to the above, there is disagreement within the psychiatric field about deinstitutionalization, appropriate care for the mentally ill, psychiatric hospitalization, economics vs. morality. The latter concerns, money to live within today's recession, treating the worried well who have money to pay vs. treating those with no money, no political power and at most newsworthy potential. If the psychiatric community rewarded and lauded its doctors for giving one to two hours a week toward solving or ameliorating the problem, perhaps more psychiatrists would contribute some time toward the mentally ill homeless social problems, any aspect they choose.

Add to all of the above the current psychiatric hospitalization policy, no cure for schizophrenia, the documented drug epidemic, problems with the educational system in terms of the drop-out rate, uneducated and unskilled adults, and our unwillingness and inability to eradicate poverty, we are faced with a recalcitrant intricate problem which is being addressed in a partialized manner.

Therefore, another partial solution is once concrete needs are met is to apply clinical theories to homeless mentally ill people, utilize theory or aspects of theory to

help establish relationships with homeless mentally ill people. Since the relationship is the conduit for the provision of services and at times is the service, how can workers effectively and efficiently establish relationships with homeless mentally ill people to link them to needed, limited resources?

There needs to be a one to one relationship with a worker a client trusts, respects, so the person can get some help. From the one to one, a group or other treatment modalities may emerge.

Establishing relationships with homeless mentally ill people seemed to be an elusive process. Some workers, programs, appear to accomplish this task easier, 'better,' than others. How specifically do they accomplish this task?

Through this descriptive, exploratory study, the researcher aimed to capture the seemingly elusive process of how to establish relationships with homeless mentally ill people, with the hope that it could be transmitted or taught to others and facilitate workers establishing relationships with homeless mentally ill people. Given the limited resources, absence of a comprehensive federal policy, absence of cohesive mental health policy which addresses this group to assist them in obtaining help, training is a critical issue.

There is the natural inclination to separate anything clinical, particularly theoretical, from homeless mentally ill people, and focus on concrete needs. However, some clinical

theory can provide a framework for understanding how a relationship is established.

Relationships

Workers were clear that they see the relationship between worker and clients as crucial to providing services to homeless mentally ill people. The differences articulated in their work with this and other populations is that with the former group, "sometimes you only have one shot" (one occasion) to impress the person with your genuineness, warmth, empathy, caring, ability to obtain results. If workers miscommunicate any of the above, the person will and can avoid you (worker), change locations, "simply get lost." Workers shared their frustration when this happens, yet, intellectually they also shared that achieving goals with homeless mentally ill people is a cumulative process. The same worker who began with a client may not see that person housed, a later worker (of a series) may.

Just as social work has over eleven different practice models or approaches to help people in distress, (outlined earlier) the mental health profession also has approaches to assist people in mental distress, in ego psychology, self psychology, Freudian psychoanalysis object relations theory.

Yet, there is an almost natural inclination to avoid clinical approaches or theories when thinking about homeless mentally ill people. The researcher suggests that we look at some of the theoretical frameworks which deal with object

(worker) and self (homeless person) as the theory relates to establishing relationships, for this could be useful in understanding how positive relationships are established between workers and homeless mentally ill people.

The same worker may not be able to see a client achieve an appropriate goal from beginning to end, due to worker turnover and client mobility.

A worker can establish a relationship with a client, seemingly very easily. Yet it is the repeated efforts of numerous workers, all conveying that they can be trusted, until finally the client risks establishing the current client/worker relationship that leads to goal achievement, housing, appropriate care for mental illness.

Although workers said they do not consciously think about steps or procedures when they establish relationships, despite program variability, the same steps or procedures were operative in most successful attempts to establish relationships with homeless mentally ill people. Variations occurred due to program protocols and/or engagement tools, however programs included for this study outlined the steps in establishing a relationship with a homeless mentally ill person as observation when possible greeting, introduction, "clear offer of help" contracting, goal achievement. All of the above assumes the context of continual assessment and relationship building.

If one uses aspects of these theoretical frameworks one can see parallels in how positive worker/client relationships are established. When a healthy simulated mothering relationship is formed between client/worker, such that the person trusts that the worker will do no harm, movement toward contracting and goal attainment occurs.

In this healthy intellectualized relationship the client feels trust, that the worker will care for him, help set appropriate boundaries, know when and how to be supportive and when to separate (let the person perform independently).

There is an assumption that establishing relationships with all homeless mentally ill people is very difficult as the majority are resistant. If one says working with homeless mentally ill people is not difficult, it suggests inexperience with the client population, little contact with the clients who are not so easily housed, due to other needs to be addressed first, medication, drug/substance problem, lack of activities of daily living skills.

However, establishing relationships with homeless mentally ill people can be similar to establishing a relationship with any other client population who may not be receptive, or welcome obviously needed help. The ability of the worker to demonstrate warmth, genuineness, empathy, make accurate assessments of client and contracting need to remain constant in establishing relationships with homeless mentally ill people and other client populations.

Poverty and mental illness have been with us for centuries. Solutions for the latter have run the gamut of lock them up, get them out of sight, to let them loose, nothing else can be done. In actuality, there is no cure for schizophrenia. Symptomatology can be muted. If one accepts the principle of thirds: one third get well, one third get worse, one third remain the same.

Alcohol/substance abuse - There is a perception that society cannot do anything about the abundance of substance/alcohol users. The influx of drugs is linked to a profit motive and illness. The debate continues that users of alcohol/substances are morally inadequate or are sick; as this debate continues the market increases. Could it be that the number of homeless has been allowed to increase so rapidly because of public perception that homeless mentally ill are primarily alcohol or substance users? As a country, we have priorities with agendas almost forced into public consciousness by popular presidents. With the Reagan Era, the message was clear, there are no homeless people, gorge yourself today in outrageous excess, tomorrow will handle itself. Many people dependent on the social service systems of cities, states and the federal government were/are affected by the Reagan Era's period of outrageous excess and social policy agenda.

Currently homelessness, mentally ill homeless people are not on the agenda. Therefore the problem continues to grow.

Conclusion

This is an exploratory/descriptive study involving 51 respondents, 42 workers, 9 administrators. The overall goal of the study was to describe the seemingly allusive process of how workers establish relationships with homeless mentally ill people for the purpose of workshop recommendations for service providers. Perhaps if more social service agencies and/or volunteer groups became involved in getting this client population to needed services, so many of our citizens would not be meandering in street asylums with garbage as their source of sustenance, and diseases once eradicated, like tuberculosis, would not be on the increase.

The reality is resources are limited for this client population who appear so needy, even though some may not be so willing to receive or be appreciative of help.

What can be done to increase resources, redefine homeless mentally ill, and public views of the homeless problem is beyond the scope of this study.

The researcher wanted to explore and document the process of establishing a relationship with a homeless mentally ill person with workshop recommendations. Perhaps if more social service agencies would lobby for increased resources, assist more homeless mentally ill people through the conduit of establishing a relationship, some of the people we see

meandering through the streets and from city to city can get the help they need. In the meantime outreach to establish relationships with clients/potential clients one by one can help.

Why should mentally ill homeless people have health care when some of housed citizens do not? Lack of medical care can lead to continued illness and spread of disease.

Since access to and resources are limited how do workers establish a relationship with homeless mentally ill people?

This project indicates that despite workers' lack of self-consciousness about steps/procedures in establishing relationship with this client group, there are standard procedures with slight variation depending on the setting protocols.

Ethnicity

Issues of race, ethnicity, racism are present, even if someone is homeless and mentally ill. The clients' feelings, thoughts are uncloaked by the intact ego function of judgment. Programs handle this issue by having a variety of people from ethnic gender and personality types so that adjustments can be made, if necessary, to suit client voiced need. Programs cater to client needs, preferences. Issues of transference/countertransference, although playing significant parts in establishing relationships with homeless mentally ill are not usually dealt with as in other clinical settings. There is no time for this. It is easier to change workers

than spend hours discussing possible causes and roots of transference/countertransference problems. The problem is not only resistance among homeless people but also the fact that it is incumbent upon the worker to prove earnestness.

Workers usually demonstrate this by consistency, sharing time, and of themselves, doing something extra that is clearly more than required, e.g. making a concerted effort to locate family/friends.

Some practice principles were advanced, as well as the thesis that establishing relationships with homeless mentally ill people is like establishing relationships with any other perhaps resistant client group. One needs skills/knowledge of engagement, assessment, contracting, basic counseling skills and a theoretical framework from which one can depart. Variation occurs after a basic theoretical framework is in place.

The most obvious difference in establishing relationships with homeless mentally ill people is, being attuned to the pre-empathy phase of engagement that Lawrence Schulman articulates. One has to prepare oneself for the unpredictability, odors and erratic behavior, all while knowing how one might (oneself) usually respond.

With the increase of homeless people and mentally ill homeless people in particular, this research addresses how service providers (existing and future) can assist in the provision of services to this vulnerable group of people until

politics, policy and public converge to address policy which affects all homeless people.

The establishment of a relationship is viewed as a crucial step prior to any service provision. Steps are outlined that can facilitate in the establishment of a relationship process. Perhaps more service providers and/or volunteers would assist during this period of transition in care for mentally ill homeless people.

Based upon workers' responses, the same social work skills of assessment, observation, contracting, communication of caring and willingness to help are needed to establish a relationship with a homeless mentally ill person as other clients who need and may be reluctant to accept help.

The differences are in some cases going to where the client is searching for, locating and involving family, the worker persistence level to continue to help and convey optimism amidst seeming client disinterest, limited resources and possible adversity. (From the client and system)

APPENDIX 1

ADMINISTRATOR INSTRUMENT

Program

1. Agency_____

2. What are your agency goals?

3. Would you consider this program a traditional or non-traditional one? (circle one)
   (Traditional is defined as more aligned with American Psychiatric Association (APA) criteria or National Institute of Mental Health (NIMH) criteria. Definitions will be taken with interviewer.)

Demographic Characteristics

3. What is your job title/position?

4. Respondent's sex: ____Female ____Male

5. Which category would you say your educational background fits best in?

   ____some college ____some graduate credits

   ____college degree ____graduate degree

   ____some doctoral work ____doctoral degree

6. Which ethnic group comes closest to yours?

   ____White (not Hispanic) ____Black (not Hispanic)

   ____Hispanic ____Asian

   ____Other (If other, explain)

7. What is the skill that you would identify as most important for an administrator to know in a program like yours?

Program Characteristics

8. Is your program monitored? ____Yes ____No

9. If yes, by whom?

10. Does your program have an outreach component?

____Yes ____No

11. Do your workers spend time engaging or establishing relationships with potential clients?

12. Which percentage comes closest to the amount of worker time is spent on engaging clients?

___less than 10% ___10-20% ___over 20%

13. How do you or your workers tell when a client is engaged?

14. Of the components listed below, which method does your program use to engage people?

a. Clear offer(s) of help from worker

(M) b. Approaching potential clients in non-threatening manner

(M) c. Offer of concrete service (food, clothing, housing)

(M) d. Consistency

(C) e. Flexibility

(C) f. Persistence

(C) g. Ability to assess client need(s)

e. Other services/methods

*M Components are methods
C Components are characterized by worker

15. What components do you consider most important for engaging clients in your program?

16. How does your program engage clients?

17. What specific steps do your workers follow to engage clients?

18. Are your workers given training on how to engage or establish relationships with clients? ___Yes ___No

19. If yes, by whom?

20. Does your program offer incentives that assist people to continue to come?

21. Do you have workers whose function it is to go out and actively seek clients for your program?

___Yes ___No

22. If yes, what amount of time is spent in actively seeking clients who may need a service like yours?

___less than 10% ___10-50% ___over 50%

Referral

23. Where are the majority of your clients from:

___another agency ___self-referrals ___other

24. How do you get your clients?

25. What is the educational range of your workers?

26. What bearing do you think education has on how clients are engaged in your program? ___Yes ___No

27. What do you consider the best educational staff mix?

28. Is there anything you would like to add that was not touched upon by this questionnaire concerning your administrative responsibilities?

SOCIAL WORKER INSTRUMENT

Worker Characteristics

1. What is your job title/position?

2. Which ethnic group comes closest to yours?

   ___White (not Hispanic) ___Black (not Hispanic)

   ___Hispanic ___Asian

   ___Other

3. How long have you worked at this program?

4. How long have you worked with this population?

5. Which category would you say your educational background fits best in?

   ___high school ___some graduate credits

   ___less than high school ___graduate degree

   ___some college ___some doctoral work

   ___college degree ___doctoral degree

6. What profession is your degree affiliated with?

7. What do you like most about your job?

8. What do you like least?

9. Do you think any special skills are needed to perform your job? ___Yes ___No

10. If yes, explain.

Style

11. Do you think a worker's style has any effect on outcome of services provided for your clients? ___Yes ___No

12. What style do you feel is most conducive to your work?

13. Is style a relevant issue for work with your population?
___Yes ___No

Worker Activity

14. Do you provide any additional services for clients/patients that are not outlined in your job description?

15. How is the majority of your time spent? (doing what)

16. Would you say this is typical for a worker in a job like yours? ___Yes ___No

Worker Perception

17. What preconceived ideas did you enter this job with which you have subsequently changed?

Skills

18. What skills do you think are most important in doing your job?

19. What would be the single most important skill a worker needs to do your job?

20. What skill do you think you utilize most in working with this population?

21. What do you think a worker needs to know prior to doing the job?

Principles

22. What are your agency's basic operating rules/principle(s)?

23. Have you experienced times when these principles conflict with personal principles?

Worker Advice

24. Retrospectively, how would you recommend a worker handle the conflict in principles?

25. Do you feel you have learned something about work with this population that others need to know? ___Yes ___No

26. If yes, explain.

27. What is the most difficult aspect of your job?

28. What do you think would ameliorate what you have mentioned?

___more training ___additional supervision

___smaller workload ___better supervision

___other (explain)

Knowledge

29. What knowledge do you think is crucial to any worker performing your job?

30. Was there any particular course in school which prepared you for your work today?

31. If yes, what?

32. If you could take a course now that you feel would help with your job, what would it be?

33. If you were running this program, what would you change?

34. What would you recommend that any worker performing your job know? (minimum)

35. Have you found any approaches to your work particularly helpful?

36. Can any other discipline do your job just as effectively?

___Yes ___No

37. If yes, explain.

If no, explain.

38. What do you think is the single most important aspect of your job?

39. Do you spend time engaging clients in the program or to services? (establishing relationships with clients?)

40. What percentage of time do you think you spend trying to establish relationships with clients?

___10% ___20% ___30% ___over 50%

41. What components do you consider most important in establishing relationships with your clients?

42. What do you do to establish a relationship with a client?

43. Did you receive any instructions or training from your agency on how to establish a relationship with a client who is homeless and mentally ill?

44. Did you receive any training that indicated establishing relationships with people who are homeless and mentally ill is more/less difficult than any other client?

45. Do you think establishing relationships with people who are homeless and mentally ill is as difficult as establishing relationships with any other client?

46. What do you do to establish a relationship with a homeless mentally ill client?

47. How can you tell when a relationship is established?

Ethnicity Issues

48. How would you categorize the ethnic breakdown of your clients?

___% White ___% Black ___% Hispanic ___% Asian

___% Other (explain)

49. What is the ethnic breakdown of workers providing service?

___% White ___% Black ___% Hispanic ___% Asian

___% Other (explain)

50. Do you think it makes any difference to your client population in terms of ethnicity who is providing the service? ___Yes ___No

51. If yes, explain.

If no, explain.

52. What could you tell a worker who is just starting with this population which might be helpful?

53. Do you find your work more or less challenging than any other job you have had?

___more ___less ___same

54. Did you prepare in any manner for this job?

55. If yes, what did you do?

56. What would you recommend that any social worker taking this job have/do?

APPENDIX 2

315 West 232 Street
1 C

Bronx, New York 10463
August 28 1990

Mr Tony Hannigan, Executive Director
Columbia Universiy Communiy Services
635 West 115th Street
New York, New York 10025

Dear Tony:

As a partial requirement for my doctoral dissertation at Hunter College School of Social Work, I am conducting an exploratory/descriptive study on how workers (specifically) establish relationships with people who are homeless and mentally ill, and I would like your help. Columbia University Community Services is one of the leaders in he provision of services to homeless people and I would like to interview workers from one of your programs on how they establish relaionships with a person who is homeless an mentally ill.

The product of my project is curriculum development. I am not evaluating the program/workers, and would appreciate your help by allowing me to interview workers from a designated program.I will call soon.

Thank you and congraulations!

Sincerely,

Tina Blake-Steele

315 West 232 Street
1 C
Bronx, New York 10463
July 2,1990

Ms. Diane Sonde
Director
Project Reachout
593 Columbus Avenue
New York 10024

Dear Diane:

As a partial requirement for my doctoral dissertation at Hunter College School of Social Work, I am conducting an exploratory/ descriptive study on how workers specifically establish relationships with clients/potential clients who are homeless and mentally ill.

The goal will be to develop a teaching tool or methodology on how to teach students to develop a relationship with a person who is homeless and mentally ill.

This study is in no way an attempt to criticize the agency or its methodology. The product of the project is curriculum development.

Copies of the interview schedule are available to you prior to interviews. I am seeking your participation in this project as your agency has been identified as a leader in the provision of services to people who are homeless and mentally ill.

Thank you for your cooperation.

Sincerely,

Tina Blake-Steele

Tina Blake-Steele

315 West 232 Street
1 C
Bronx, New York 10463
July 8, 1990

Mr. Mark Vogel. Director
BBCS-TLC
116 Williams Avenue
Brooklyn, New York 11207

Dear Mr. Vogel:

As a partial requirement for my doctoral dissertation at Hunter College School of Social Work, I am conducting an exploratory/descriptive study on how workers specifically establish relationships with clients/potential clients who are homeless and mentally ill.

The goal will be to develop a teaching tool or methodology on how to teach students to develop a relationship with a person who is homeless and mentally ill.

This study is in no way an attempt to criticize the agency or its methodology The product of the project is curriculum development.

Copies of the interview schedule are enclosed (2) for your review.

I am seeking your participation in this project as your agency has been identified as a leader in provision of services to people who are homeless and mentally ill.

Thank you for your cooperation.

Enc.

Sincerely,

Tina Blake-Steele

314 West 232 Street
1 C
Bronx, New York 10463
July 8,1990

Mr Murray Itzkowitz, Executive Director
The Bridge, Inc.
248 West 108th Street
New York,New York 10025

Dear Murray:

As a partial requirement for my doctoral dissertation at Hunter College School of Social Work, I am conducting an exploratory/descriptive study on how workers specifically establish relationships with clients/potential clients who are homeless and mentally ill.

The goal will be to develop a teaching tool or methodology on how to teach students to develop a relationship with a person who is homeless and mentally ill.

This study is in no way an attempt to criticize the agency or its methodology. The product is curriculum development. Copies of interview schedules are available to you prior to interviews.

I am seeking your participation in this project as your agency has been identified as a leader in provision of services to people who are homeless and mentally ill.

Thank you for your cooperation.

Sincerely,

Tina Blake-Steele

315 West 232 Street
1 C
Bronx, New York 10463

July 9,1990

Mr. Elie Valencia, Director
Services for the Homeless
Psychiatry Department
622 West 168th Street
Columbia Presbyterian Medical Center
New York, New York 10032-3784

Dear Mr. Valencia:

As a partial requirement for my doctoral dissertation at Hunter College School of Social Work, I am conducting an exploratory/descriptive study on how workers specifically establish relationships with clients/potential clients who are homeless and mentally ill.

The goal will be to develop a teaching tool or methodology on how to teach students to develop a relationship with a person who is homeless and mentally ill.

This study is in no way an attempt to criticize the agency or its methodology. The product is curriculum development. Copies of interview schedules are available to you prior to interviews.

I am seeking your participation in this project as your agency has been identified as a leader in the provision of services to people who are homeless and mentally ill.

Thank you for your cooperation.

Sincerely

Tina Blake-Steele

315 West 232 Street
1 C
Bronx, New York 10463
July 14, 1990

Mr. Louis Cuoco, Director
CSS I & II/Homeless Project
Bellevue Hospital Center
First Avenue and 27th Street
New York, New York 10016

Dear Lou:

As a partial requirement for my doctoral dissertation at Hunter College School of Social Work, I am conducting a descriptive/exploratory study on how workers specifically establish relationships with clients/potential clients who are homeless and mentally ill.

The goal will be to develop a teaching tool or methodology on how to teach students to develop relationdhips with a person who is homeless and mentally ill.

This study is in no way an attempt to criticize the agency or its methodology. The product of the project is curriculum development.

Copies of the interview schedule are available to you prior to interviews. I am seeking your participation in this project as your agency has been identified as a leader in the provision of services to people who are homeless and mentally ill.

Thank you for your cooperation.

Sincerely,

Tina Blake-Steele

315 West 232 Street
1 C
Bronx, New York 10463
July 14, 1990

Ms. Jackie Rivers, Program Director
Homeless Outreach Project
513 West 166th Street
New York, New York

Dear Jackie:

As a partial requirement for my doctoral dissertation at Hunter College School of Social Work, I am conducting a descriptive/exploratory study on how workers specifically establish relationships with clients/potential clients who are homeless and mentally ill.

The goal will be to develop a teaching tool or methodology on how to teach students to develop relationships with a person who is homeless and mentally ill.

This study is in no way an attempt to criticize the agency or its methodology. The product of the project is curriculum development.

Copies of the interview schedule are available to you prior to interviews. I am seeking your participation in this project as your agency as been identified as as a leader in the provision of services to people who are homeless and mentally ill.

Thank you for your cooperation.

Sincerely,

Tina Blake-Steele

BELLEVUE
HOSPITAL CENTER
New York City
Health and Hospitals
poration
t Avenue
and 27th Street
New York, N.Y 10016

179

July 19, 1990

Tina Blake-Steele
315 West 232 Street, 1C
Bronx, New York 10463

Dear Ms. Blake-Steele,

As per our discussions, the Bellevue CSS Homeless Project would be delighted to participate in such a worthy endeavor. Of course we would appreciate the sharing of your conclusions and suggestions once all of your data has been analyzed.

If I can be of any assistance in either scheduling meetings, providing an historical overview of the program and its host agency, or in any other way please contact me at (212)561-4265.

Sincerely,

Louis F. Cuoco, ACSW
Director
BHC - CSS

315 West 232 Street
1 C
Bronx, New York 10463
August 28, 1990

Ms. Jacqueline Rivers, Director
Homeless Outreach Program (HOP)
The Presbyterian Hospital
622 West 168th Street1207
New York, New York 10032 Att. VC-5 Psychiatry
Dear Ira:

Thank you and your staff for helping me with my research project. Your assistance is priceless!

Keeping in mind that I am not evaluating the program/workers, my product is curriculum development, enclosed is a draft of what I think needs to be included about the program. Feel free to change anything you want to.

Enclosed is a self-addressed, stamped envelope for you to return the draft to me as soon as you can.

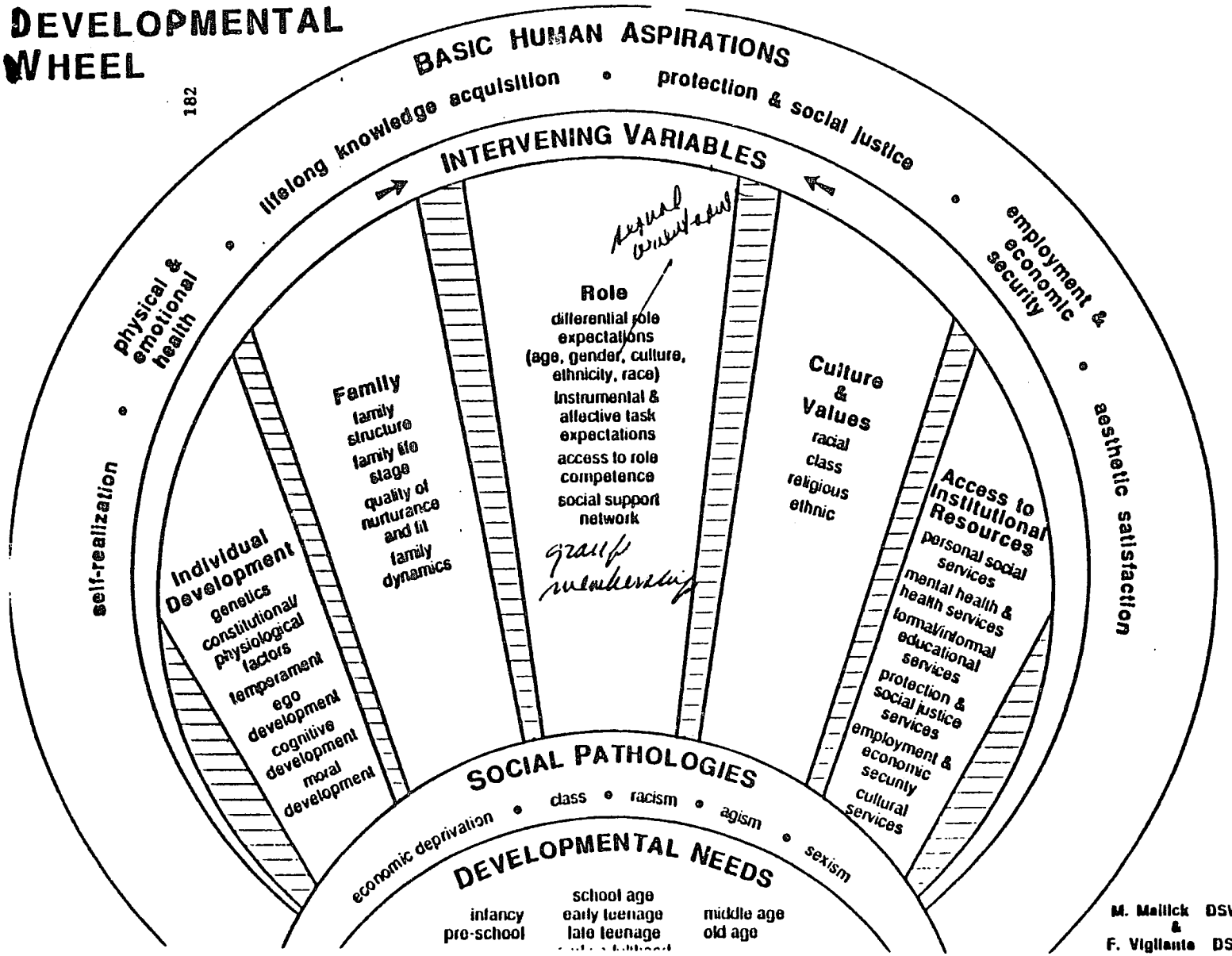
If you have any concerns, please call me at (212)796-4130. Thank you again.

Sincerely,

Tina Blake-Steele

APPENDIX 3

DEVELOPMENTAL WHEEL



M. Mallick DSW
&
F. Vigilante DSW

GODDARD-RIVERSIDE COMMUNITY CENTER'S

PROJECT REACHOUT

(212) 595-3066

Services and Advocacy for the Mentally Ill Homeless

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