GRADY HEALTH SYSTEMS COMMUNITY OUTREACH SERVICES: A STUDY OF PROGRAM EFFICACY

by

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(Under the Direction of Larry Nackerud)

ABSTRACT

Currently, the social attitude concerning homelessness has benefited from the past 30 years of research conducted both publicly and privately. Rather than being seen as personal choice or individual defects, homelessness is seen as a socially constructed failure that occurs when families and individuals experience one or more catastrophic insults from which they lack the resources or social support to recover. The homeless individual epitomizes the culmination of poverty, lack of education, lack of social skills, severe mental illness, substance abuse, and severed family ties that fall far below the level that is acceptable for a human being to thrive.

The Grady Health System Community Outreach Services [COS] embraces the concept of integrated services in addition to flexible community outreach for ancillary services to the homeless consumer suffering from mental illness and/or substance abuse in the belief that this model provides optimum treatment for this population. COS social workers have provided services and care for this multi-needy group for over twenty-seven years without the benefit of evaluating the efficacy of their service delivery.

The following research study is a confirmative program evaluation centered on determining the efficacy of the integrated services approach provided by the clinical staff of the COS. The data collected provided information to establish the failure to reject the two hypothesis in the research study: (1) There was not an over-all self-reported improvement in the quality of life of the COS consumer as measured by the BASIS-32 (Eisen, Dill, & Grob, 1994); and, (2) There was not a reduction of hospitalization rate in the geriatric COS consumer. Further descriptive data demonstrated that: (3) Flexibility of interventions was documented at a sub-standard level; (4) Contact with family/significant others was documented at a sub-standard level; (5) First contact with homeless individuals is documented at an above-standard level; and (6) Discharges from the COS are predominantly due to documented refusal of services.

The program evaluation provided valuable information concerning the efficacy of the current service delivery to the consumer. The conclusion provides recommendations provided by the researcher that The Grady Health System reviewed and subsequently adopted.

INDEX WORDS: Homelessness, Social Work, Service delivery, Integrated services, Best Practices Model

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DEDICATION

To my husband Pat, our son John, and our daughter Samantha – you are extraordinary people.

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INTRODUCTION

The Grady Health System Community Outreach Services (COS) is a program managed by the Grady Health System Department of Mental Health Services. COS originated in 1974 during the start of the ‘community support’ reform era for the purpose of providing mental health and psychiatric continuity of care for those consumers suffering with mental illness and living on the street, in boarding homes or shelters after being discharged (deinstitutionalized) primarily from the Central State Hospital of Georgia. COS offers mental health treatment and social work services to consumers living in Fulton County that have a primary psychiatric diagnosis (schizophrenia, manic-depression and all other Axis 1 diagnosis) in addition to: a) a substance abuse diagnosis, or, b) elderly with psycho-social problems, or, c) homeless or those persons in danger of becoming homeless, and d) families of consumers in need of psycho-social education (Grady Health System, 2002). The Grady Health System Community Outreach Services [COS] embraces the concept of integrated services in addition to flexible community outreach for ancillary services to the homeless in the belief that this model provides optimum treatment for this population.

The following research study is a “confirmative program evaluation” centered on determining the efficacy of the integrated services approach provided by the clinical staff of the COS (Misanchuck, 1978). This is the first time the COS experienced an external evaluation of service delivery to consumers. The data collected provided information to establish the failure to reject the two hypothesis in the research study: (1) There was not an over-all self-reported improvement in the quality of life of the COS consumer as measured by the BASIS-32 (Eisen, Dill & Grob, 1994); and, (2) There was not a reduction of hospitalization rate in the geriatric COS consumer. Further descriptive data demonstrated that: (3) Flexibility of interventions was documented at a sub-standard level; (4) Contact with family/significant others was documented at a sub-standard level; (5) First contact with homeless individuals is documented at an above-standard level; and (6) Discharges from the COS are predominantly due to documented refusal of services.

The program evaluation provided valuable information concerning the efficacy of the current service delivery to consumers. The conclusion provides recommendations provided by the researcher that The Grady Health System reviewed and subsequently adopted.

Background

The social attitudes and resulting structural responses concerning the public provision of care for those persons suffering from chronic mental illnesses has gone through several major changes in American history (Grob, 1994). Mental illnesses/disorders are a complex and serious disease process. In modern times, mental illnesses/disorders are defined within a matrix that combines the biological input, the psychological impact, and the social and cultural influences (Stoudemire, 1998). Through the process of research and education, the understanding has emerged that mental illnesses/disorders are not what a person is; this is a condition they have.

Although a better comprehension of mental illness disease process and numerous types of medications and treatment modalities is evolving, the care of the seriously chronically mentally ill person still remains a serious social issue in America. The resulting short-comings of each of the four reform eras place into motion the current sub-standard living conditions of our most seriously mentally consumers. Options and choices are lost for these consumers as they are reduced to homelessness and its plaguing and often fatal problems. The belief that the homeless are just lacking permanent shelter is a horrible simplification of the issues surrounding homelessness. The lack of momentum to sustain stable housing is only a visible result of the culmination of catastrophic insults rendering the individual incapable of any sufficient level of self-determination (Bellack & DiClemente, 1999; Carey, 1996; Drake, 1996; Drake, Essock, et al., 2001; Drake & Wallach, 2000; North & Smith, 1993; Swofford, Kasckow, Scheller-Gilkey, & Inderbitzen, 1996).

In the early 1800s, ‘moral treatment’ in asylums (a place offering protection or safety) was designed to provide early intervention by targeting restoration of mental health and prevention of chronic illness (Goldman and Morrissey*,* 1985; Grob, 1994; Morrissey & Goldman, 1984; U.S. Department of Health and Human Services, 1999). States built either public or private asylums for the early treatment of mental illness in a controlled environment. Early treatment objectives were primarily centered on the restoration of mental health and prevention from having a chronic mental condition (Grob, 1994; U.S. Department of Health and Human Services, 1999). The era of ‘moral treatment’ demonstrated some success in the area of restoration, but made little impact on the prevention of chronic mental illness (U.S. Department of Health and Human Services, 1999). The asylums became seriously crowded with persons suffering from chronic mental conditions and financial constraints bound the ability to provide therapeutic care. The era of moral and compassionate care ended in disillusionment.

The second major public reform of ‘mental hygiene’ showed signs of influence in the public sector several decades after the end of the Civil War. Lack of funding, increasing of overcrowding and failure to deter the development of chronic mental illness turned public policies to embrace the ‘metal hygiene’ reform movement (Goldman & Morrissey*,* 1985; Grob, 1994; Morrissey & Goldman, 1984; U.S. Department of Health and Human Services, 1999). The ‘mental hygiene’ movement also espoused early treatment (in the form of outpatient clinics) and the belief that chronic mental illness could be prevented (Goldman and Morrissey, 1985; Grob, 1994; Morrissey & Goldman, 1984; U.S. Department of Health and Human Services, 1999). Consumers were admitted to special units within medical hospitals affiliated with university research centers. Mental health science and medicine was now associated with medical science. The newly formed National Committee for Mental Hygiene (renamed the National Mental Health Association [NMHA]) provided a strong leadership role during this era. Despite the efforts of the ‘mental hygiene’ era, consumers suffering from chronic mental illness still filled asylums and serious financial problems compounded the ability to provide care and treatment for those persons living during the Great Depression and the start of World War II.

The third reform movement of ‘community mental health’ obtained momentum from several sources during this time. The NMHA, the Group for the Advancement of Psychiatry, newly developed brief treatment techniques, and the development of psychotropic medications pushed forward the cornerstone policies of deinstitutionalization and community care in the mid 1900’s (Goldman & Morrissey, 1985; Grob, 1994; Morrissey & Goldman, 1984; Talbott, 1982; U.S. Department of Health and Human Services, 1999). This reform era experience the discharge of the chronic, custodial consumer back into communities. In addition, dementia consumers were transferred to nursing homes for long term care. Despite the well meaning hopes of the ‘community mental health’ era, communities were not philosophically prepared, physically equipped or monetarily funded to provide the care necessary for persons suffering from serious chronic mental illness to thrive in this setting (Goldman & Morrissey, 1985; Grob, 1994; Morrissey & Goldman, 1984; Stern 1984; U.S. Department of Health and Human Services, 1999; Wolff & Stuber, 2002). The discharge of approximately 75% of the nation’s inpatient mental health residents added to the natural prevalence of occurring mental illness, creating a population of individuals struggling to live and communities struggling to help them live (Goldman & Morrissey, 1985; Morrissey, 1982; Morrissey & Goldman, 1984).

The short comings and lessons learned from the ‘community mental health’ reform movement provided the impetus for growth of the current reform movement of ‘community support’ (Goldman & Morrissey, 1985; Grob, 1994; Morrissey & Goldman, 1984; U.S. Department of Health and Human Services, 1999). Although early treatment did not stop the chronic development of some mental illnesses, ‘community support’ seemed to keep consumers out of long term institutionalization and improve the quality of life (Goldman & Morrissey, 1985; Grob, 1994; Morrissey & Goldman, 1984; U.S. Department of Health and Human Services, 1999). New treatment techniques, atypical psychotropic medications, and more effective psychosocial interventions is the framework of reference in the current reform of ‘community support’ for persons suffering from chronic mental illness (Goldman & Morrissey, 1985; Grob, 1994; Morrissey & Goldman, 1984; Talbott, 1982; U.S. Department of Health and Human Services, 1999). It was during the early stages of the ‘community support’ reform movement (1970’s) that the Grady Health System Community Outreach Services [COS] was created to respond to the needs of its discharged and/or deinstitutionalized consumers suffering from serious mental illness returning back to their communities in the Atlanta Metropolitan area. The following is description of the COS, how this program provides its service delivery, and how it interfaces with the ‘community support’ reform movement.

Community Support – The Grady Health System Community Outreach Services

Grady Health System Community Outreach Services (COS) is a program managed by the Grady Health System Department of Mental Health Services. The Department of Mental Health

Services is one of many departments that specialize in a particular aspect of overall physical health and well being within the Grady Health System of Fulton County in Atlanta, Georgia. COS originated in 1974 during the start of the ‘community support’ reform era for the purpose of providing mental health and psychiatric continuity of care for those consumers suffering with mental illness and living on the street, in boarding homes or shelters after being discharged (deinstitutionalized) primarily from the Central State Hospital of Georgia. Persons released from jails and prisons were also served. The charter program was known as Community Care and was staffed by two social workers, a nurse, and a psychiatrist. Over the years, the program has evolved to meet the needs of an ever growing, constantly changing group of consumers. The program name was eventually changed to Community Outreach Services (COS), located at Hirsch Hall Building, and is currently staffed by seven social workers, a Therapeutic Recreation Specialist, a Therapeutic Recreation Technician, a Psychiatrist, and a substance abuse counselor. COS also dedicates time and personnel resources into training third year Emory University and Morehouse Psychiatry Residents in this specialized area. COS incorporates a multi-disciplinary team approach, lead by social workers, to deliver flexible mental health care, clinical case management, and integrated community resource services to those consumers that have mental illness (and their families) that are unable to access and successfully negotiate traditional day program and clinical outpatient mental health services offered within the Atlanta Metropolitan area (Grady Health System, 2002)

COS offers mental health treatment and social work services to consumers living in Fulton County that have a primary psychiatric diagnosis in addition to: a) a substance abuse diagnosis (people with a diagnosis of mental illness and a co-morbid substance abuse-dependency diagnosis are referred to as being dual diagnosed as defined in Drake, Essock, Shaner, Carey, Minkoff, Kola, Lynde, Osher, Clark & Rickards, (2001), or, b) elderly with psycho-social problems, or, c) homeless or those persons in danger of becoming homeless, and d) families of consumers in need of psycho-social education.

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COS offers mental health treatment and social work services to consumers living in Fulton County that have a primary psychiatric diagnosis (schizophrenia, manic-depression and all other Axis 1 diagnosis) in addition to: a) a substance abuse diagnosis, or, b) elderly with psycho-social problems, or, c) homeless or those persons in danger of becoming homeless, and d) families of consumers in need of psycho-social education (Grady Health System, 2002).

Service Delivery

Although the COS is not designed after a specific model that prescribes certain procedures of service delivery to provide care and treatment for the chronically mentally ill, there are some aspects of care provided that follow particular patterns within a certain approach of reference. The Medical Director, Director, social workers, residents and medical students within the program refer to the biopsychosocial approach (Stoudemire, 1998) to explain the causes of this disease process and to help formulate the approach by which to assess and treat mental illness. According to Stoudemire (1998) “This approach inherently validates the potential importance of biogenetic, psychological, social, and environmental factors in the diagnosis and treatment of the patient” (p. 75). The following is a summary of the conceptual and philosophical foundations of the biopsychosocial approach as outlined by Dr. Stoudemire (1998):

> 1. Genetic and biological factors are deemed to be of major importance in the pathogenesis and treatment of certain psychiatric disorders (such as schizophrenia and mood disorders) and also may play a part in determining the patient’s resilience or vulnerability to stress.
> 2. Certain problematic developmental experiences and conflicted relationships within the family and social system may confer vulnerabilities to certain types of psychiatric illnesses; alternatively, positive developmental experiences and relationships and good social support may provide a buffering effect.
> 3. Current life stressors may precipitate the onset of certain psychiatric disorders any symptoms or contribute to relapses of preexisting conditions (p. 76).

Following this approach, the biological aspects of mental illness are treated with medications - primarily antipsychotics, mood stabilizers, and antidepressants. The psychological aspects of treatment are administered by social workers (both licensed and unlicensed) primarily providing forms of support therapy. There are no trained specialized forms of therapy (such as behavioral modification) being provided currently by the social workers at the COS. The social workers also provide case management services. The social aspects of treatment are provided by social groups and day treatment programs also provided within the Grady Health System network (i.e. Social Skills Group, Alcohol Anonymous, Narcotics Anonymous, and Double Trouble).

An additional potential frame of reference for program management is the Policy and Procedures Manuel for the Grady Health System (Grady Health System, 1998). Perusal of this manual did not elucidate any addition aspects of models, treatments, or approaches by which the COS provides service delivery. At the time of this research study, COS did not bill for services under Medicaid or Medicare regulations; therefore, there were not any state or federal guidelines directing requirements for the level of minimum care (how many physician visits per month, how many clinician visits per month, and how many community visits per month). Each social worker was assigned a case load of approximately 30 consumers and required to have 2 ‘contacts’ a month. These contacts could vary from: 1) face-to-face at COS, 2) face-to-face in the community, 3) telephone, or 4) written form. Each psychiatrist and social worker is responsible for providing a contact sheet for each consumer they have provided a service for by the end of the working day. The primary reference for this contact sheet is to exact billing information and generate funds.

A final frame of reference provided by the Medical Director and the Director is that the COS practices what is known as ‘community mental health.’ According to Kaplan and Sadock (1981), ‘community mental health’ should provide: 1) emergency services, 2) outpatient services, 3) partial hospitalization, 4) inpatient services, 5) consultation-education services, and under Public Law 94-63; 6) follow-up services for those who have been hospitalized, 7) transitional housing services, 8) alcoholism services, and 9) substance abuse services. Although all these services are not provided by the COS, the Grady Health System does provide all these services in limited form to its consumers. The aspects of ‘community mental health’ that the COS focuses on are: 1) outpatient care, 2) community visits, 3) housing referrals, 4) case management, 5) substance abuse, 6) follow up after hospitalization, incarceration, or institutionalization, and 7) consultation and education (Grady Health System, 2002).

Instrument use within the COS

The first standardized instrument required and used universally within the COS is the Abnormal Involuntary Movement Scale [AIMS] (National Institute of Mental Health, 1976). This scale is used to assess and measure involuntary movement in consumers receiving neuroleptic treatment (dopamine-receptor blocking agents, most commonly classic antipsychotics) (Stoudemire, 1998). According to Grady Health System Policy and Procedure as mandated by The Georgia Department of Human Resources (Grady Health Systems, 1998), the AIMS (National Institute of Mental Health, 1976) is used at the onset of neuroleptic treatment and every six months thereafter. If the onset of involuntary movement occurs (this is called tardive dyskinesia [TD]), the treating psychiatrist is to document the procedures of treatment and note the severity of TD at each contact with the consumer. Use of this instrument is consistent with standard and customary care in the community mental health field. Initially, assessment of the use of the AIMS within the COS was considered; however, full implementation of the AIMS had not been achieved at the time of this study. The second standardized instrument required by Grady Health System Policy and Procedure and The Georgia Department of Human Resources for universal use at the COS is the Behavioral and Symptom Identification Scale [BASIS-32] (Eisen et al., 1994; Grady Health System, 1998). The BASIS-32 is a 32 question behavioral assessment tool that provides a numeric score on the following five subscales: a) Relation to Self and Others (seven questions); b) Depression and Anxiety (six questions); c) Daily Living and Role Functioning (nine questions); d) Impulsive and Addictive Behavior (six questions); and, e) Psychosis (four questions) (McLean Hospital, 2003). This instrument is a self-report test that assesses treatment outcomes from the client's perspective over the past week. The consumer is asked to rank their answers from "0" or "no difficulty"; "1" or "a little"; "2" or "moderate"; "3" or "quite a bit"; and, "4" or "extreme" for each area of assessment (McLean Hospital, 2003). In the area of "Relation to Self and Others" questions focus on: the relationships with family members; getting along with other people; feeling close to others; being realistic; expression of emotions; goals in life; and, lack of self-confidence (McLean Hospital, 2003). In the area of "Depression and Anxiety" questions focus on: adjusting to major life stressors; feelings of loneliness; depression; suicidal feelings; negative physical symptoms; and, fear or anxiety (McLean Hospital, 2003). In the area of "Daily Living and Role Functioning" questions focus on: managing day-to-day living; household chores; work related issues; school related issues; leisure activities; autonomy; apathy; confusion or memory problems; and, satisfaction with life (McLean Hospital, 2003). In the area of "Impulsive and Addictive Behavior" questions focus on: mood swings; uncontrollable behaviors; drinking alcohol; taking illegal drugs; controlling temper; and, impulsive behaviors (McLean Hospital, 2003). In the area of "Psychosis" questions focus on: disturbing thoughts; hearing voices or seeing things; bizarre behavior; and sexual preoccupation (McLean Hospital, 2003).

The instrument has been in existence since 1984 and is used in over 800 locations throughout the world (McLean Hospital, 2003). The BASIS-32 is also accepted by the Joint Commission on Accreditation of Healthcare Organizations as an acceptable system for the accreditation process (McLean Hospital, 2003). An excellent synopsis provided by Russo and Roy-Byrne (1997) provides the following information concerning "implications for mental health services delivery" (p. 212) for the BASIS-32:

> The patient-rated BASIS-32 is a relatively brief and inexpensive measure that produces reliable and valid outcome data when used with severely ill psychiatric inpatients. The results demonstrated that the self report instrument has the capacity to discriminate diagnostic groups and measure changes in psychological and social functioning in patients during the course of treatment. The administration and scoring of the measure takes approximately 5 minutes of staff time in comparison to 20 or more minutes required for the interview format. The minor administrative burden of this measure is out-weighted by is clinical utility. Information from longitudinal assessments of the BASIS could potentially be used for quality assurance and consumer information purposes. The use of this instrument is recommended as part of a psychiatric outcome program. (p. 212)

Additional research evaluating the self-report use of the BASIS-32 further solidifies the utility of this instrument. Hoffman and Capelli (1997) evaluated the BASIS-32 on two groups of consumers (n=462 adults and n=244 adolescents). The results of this study “confirm the utility of the BASIS-32 as a brief, self-report assessment tool for adult inpatients, even when the patients complete the instrument themselves rather than through interview format” (Hoffman et al. 1997, p. 325). Because of the instrument’s establishment as a reliable and valid tool, the BASIS-32 is recommended by the American Association for Partial Hospitalization (Outcome Measures Protocol, 1994) for use in outcomes assessment. Finally, a study by Eisen, Wilcom, Left, Schaefer, and Culhane (1999) established the BASIS-32 as a useful instrument in measuring outcomes in an outpatient setting with consumers that have a “broader range of behavioral health problems including substance abuse and psychotic symptoms…” (page 9). At the COS, the BASIS-32 is administered within 30 days of the first appointment, then again one year there after. Although the BASIS-32 is used by each clinician, there is not an incorporated policy or procedure at the COS for periodic administration, scoring, interpreting, discussing the results with the consumer, or documentation within the record concerning the use of the instrument.

The Grady Health Services COS participation in a Continuum of Care for the Homeless

The Grady Health Services COS works in a collaborative effort with St. Joseph’s Mercy Care Services (primary medical care), The ROCK (transitional housing plus auxiliary services), and The Welcome House (adult residential apartment complex) to provide services to the homeless/near homeless in the Atlanta Metropolitan area. The Continuum of Care [CoC] is called the Safe Haven/Permanent Housing Demonstration Project. The Safe Haven/Permanent Housing Project is a three-step, multi-agency collaborative effort that provides specialized service delivery to homeless persons with chronic/serious mental illness and substance abuse issues (dually diagnosed) toward achieving the goal of supported independent living or independent living.

The first step of outreach starts with contacting the homeless where they congregate, forming relationships, and building trust in the consumer and the community. This service is provided by the Saint Joseph's Mercy Care Services [SJMCS] and Grady Health Systems Community Outreach Services. Central Atlanta Progress [CAP] funds SJMCS while a Substance Abuse and Mental Health Services Administration [SAMHSA] Grant funds the Community Outreach Services.

The second step of transition and stabilization is initiated when willing individuals are enrolled in The Safe Haven transitional housing located in downtown Atlanta and operated by the The ROCK. The Safe Haven offers residential and clinical support on 24/7 basis. Psychiatric and substance abuse treatment will be provided by the Grady Health Systems Community Outreach Services. Primary medical care is provided by SJMCS**.** The Georgia Department of Human Resources [DHR] through a Fulton Regional Board contract, funds the residential staffing for The Safe Haven. The current estimated length of stay at the Safe Haven is approximately one year.

The third step of re-domicilation occurs when individuals have successfully completed their stay at The Safe Haven transitional housing and are ready for permanent housing. Graduating individuals will transfer to one of sixteen permanent housing units located at The Welcome House furnished apartment complex located in downtown Atlanta. SJMCS will provide the supportive services for the permanent housing consumer, which will include case management, counseling, goal development, computer training, interview skill training, referrals to GED classes, and referrals to substance abuse treatment. The Welcome House has five on site computers for basic computer orientation. Further computer training will be conducted at SJMCS's Computer Training Facility at the Imperial (an apartment complex). Consumers in need of clinical support will be followed by the Grady Health Systems Community Outreach Services HOPE Teams. Medical referrals for primary care are followed at SJMCS's clinical sites. The Fulton Regional Board also funds the supportive services and the Department of Housing and Urban Development [HUD] subsides the permanent housing units through the McKinney Act Shelter Plus Care [S + C] program.

Those persons suffering from chronic mental illness and substance abuse with the additional severe burden of homelessness are among the worst of the oppressed. Although the COS has provided services to this population for over 25 years, little is known empirically about the efficacy of their service delivery to this frail and disenfranchised population. The intent of this research is to add to the knowledge base in this area and to provide the first evaluation of service delivery in the history of the Grady Health System Community Outreach Services program.

Statement of the Problem

Current research reports people that suffer from chronic mental illness and are homeless are permeated with chronic disabilities, acute exacerbations of mental illness, personality disorders, legal issues, poor interpersonal skills, limited or non-existing resources, distancing family support, and limited advocacy skills (North & Smith, 1993, p. 429-430). Additional research from an Epidemiologic Catchment Area (ECA) study (Regier, Farmer, Rae, Locke, Keith, Judd & Goodwin, 1990) further exemplifies the incidence of co-morbid substance abuse-dependence for those individuals suffering from chronic mental illness. This ECA study found that 47% (n = 20291) of those persons with a lifetime disorder of schizophrenia or schizophreniform disorder also met the criteria of substance abuse-dependence. In addition, the study reports the occurrence of a lifetime history of alcoholism with any lifetime mental disorder diagnosis is 22.3% - the rate of alcoholism with no history of mental disorder is 11.0% (Regier et al. 1990). Furthermore, this ECA study also found that 14.7% of those persons with a lifetime mental disorder also abuse or are dependant on other drugs while the rate of drug abuse-dependence with no history of mental illness is 3.7% (Regier et al. 1990). Finally, this study reports for those individuals with a diagnosis of antisocial personality disorder, some form of substance abuse is identified in 83.7% of this group (Regier et al. 1990). All these additional issues exponentially compound the problems associated with the care and treatment of persons suffering from chronic mental illness.

Living in the street is a difficult and harsh life. There is no safe haven (such as stable shelter) from which to escape the unrelenting external environment. In evaluating what happens to the personality make-up of an individual under such conditions, two theories present themselves as providing some guidelines for answers. The first is behavioral theory. In brief, behavioral theory provides the framework from which to measure objectively behavior occurring in the environment is such a way that " the nature of the relationships between behavior and the environment are explored, described, and analyzed…"(Stoudemire, 1990, p. 85). Further, behavioral theory proposes the rule that behavior will be reinforced when a desired outcome is achieved. In the case of a homeless person, hostility protects against being approached or possibly attacked. According to this theory, avoidance behavior is strengthened because it diverts contact with an adverse event (Stoudemire, 1990).

A second plausible theory of explanation of behavior is systems theory. Using this theory, the living organism makes changes in its behavior based on feedback in order to achieve its goals (Napier & Whitaker, 1978). The behaviorist views the individual as reactionary, capable of coping to a changing environment and learning new skills. If this theory is indeed reliable and valid, then it is not at all unreasonable to view the antisocial behaviors of the homeless individual as learned coping skills to deal with a hostile environment. A homeless person is rewarded if no one approaches them or even worse, attacks them. They will continue to display avoidant, aggressive, or antisocial behavior indefinitely or until a new set of learning conditions takes place. The behaviors of the homeless person should not be seen as sick or dysfunctional – rather, these behaviors should be evaluated in context of the system that brings them to bear (Napier & Whitaker, 1978). It is within this framework of harsh and unusual circumstances that the treatment community embraces its work with the homeless mentally ill population.

Among the many issues faced by social workers providing services for the homeless chronically mentally ill persons, some of the more serious problems include: relapse of either or both mental illness and substance abuse, repeated re-hospitalization, domestic and community violence, arrest and imprisonment, homelessness, decreased functional states, HIV infection, serious medical illness, and chronic non-compliance with treatment (Bellack & DiClemente, 1999; Carey, 1996; Drake, 1996; Drake, Essock, et al., 2001; Drake & Wallach, 2000; North & Smith, 1993; Swafford, Kasckow, Scheller-Gilkey & Inderbitzen,1996). The approach of integrated mental health services and substance abuse intervention for the homeless chronically mentally ill (at least in concept) purports to reduce exclusion from separate services and fragmentation of service delivery at the clinical level (Drake & Wallach, 2000). Integration of services also reports a reduction in emergency room use, medical hospitalization, mental health hospitalization, and incarceration (Proscio, 2000). COS embraces this concept of integrated services in addition to flexible community outreach for ancillary services in the belief that this model provides optimum treatment for this population.

COS social workers have provided services and care for this multi-needy group for over twenty-seven years, demonstrating this profession's perennial dedication to improving the quality of life for this frail and disenfranchised population. During this span of time, however, a program evaluation of COS services has not been done to determine the effectiveness or goal attainment of those services provided. In fact, evaluation of integrated service programs for the dual diagnosed is reported sparingly in the literature (Bellack & DiClemente, 1999; Drake, 1996; Drake & Essock, et al., 2001; Drake & Wallach, 2000; McHugo, Drake, Burton & Ackerson, 1995; Minkoff, 1989). Furthermore, according to Drake and Essock et al. (2001, p. 437) "few efforts have been made to study these efforts at the systems level." It is the expressed desire of the COS management and professional staff to insure the ongoing quality of its services, therefore necessitating this program evaluation. Therefore, the problem and focus of this study is to elucidate whether the integrated services provided by the clinical staff of the COS does in fact, benefit this chronically sick consumer population.

Development of Research Approach

The COS has provided mental health services to Atlanta communities for over 25 years. Since this program has been operating for a significant period of time, neither formative nor summative evaluations capture the purpose of this study (Fitzpatrick, Sanders, & Worthen, 2004; Worthen, Sanders & Fitzpatrick, 1997). Misanchuck's (1978) description of a confirmative evaluation – conducted when a program has been in existence for a significant period of time to determine how well it has met its objectives – best describes this study. In addition, the request of the COS for an external evaluator that would work in collaboration with the program and its staff further expands the need for stages of development of this study. When all these factors were taken into consideration, this research study required four stages of development prior to data gathering.

The first stage began with the organization and appointment of an Advisory Team. The team members included the COS Medical Director, Dr. Rosalind Mance; COS Director, Shelia Beckum-Head; appointed social workers; staff (as indicated); and consumers (during the data collection stage). During the first stage, interviews were conducted with the Advisory Team by the researcher to determine the evaluation approach needed to provide empirical evaluation information concerning service delivery to the consumers of the COS. The objectives-oriented approach (commonly referred to as the Tylerian Evaluation Approach) was determined to be the best fit for evaluating service delivery. The objectives-oriented approach utilizes evaluation as the method of determining the level at which the goals of a program are truly (empirically) obtained (Fitzpatrick et al. 2004; Worthen et al. 1997). This process includes: a) establishing goals or objectives; b) classifying the goals or objectives; c) defining objectives in behavioral terms; d) finding situations objectives are used in; e) developing or selecting measuring techniques; f) collecting data; and g) comparing data with behaviorally stated objectives (Fitzpatrick et al. 2004; Worthen et al. 1997, p. 82).

The second stage was comprised of a series of open-ended interviews with the members of the Advisory Team for the purpose of developing themes that related to the objectives and goals of the COS. The notes from the open-ended interviews were reviewed by the researcher and the themes were organized into common groups of ideas.

The third stage took form as the divergent process of interviewing and organizing common groups of ideas was replaced with the convergent process of development of specific questions. Specific to this research study, the objectives and goals set by the program were the foundation for development of the hypotheses tested and the questions evaluated. The specific questions that arose out of the convergent process were given to the Advisory Team to prioritize. The Advisory Team agreed to the evaluation of four questions. These questions centered on issues concerning the quality of life of COS consumers, achievement of COS goals (hospitalization rates, contact with consumers, contact with family and significant others, referral services, and services to the homeless), and discharge information.

The fourth stage began with the development of the two hypotheses and five descriptive variables that were the focus of this study. During this stage, it was determined that the design of this confirmative, objectives-orientated study would be a cross-sectional, correlational, quantitative-descriptive, Sub-type B program evaluation (Tripodi, Fellin & Meyers, 1983). The purpose of a correlational study is two fold: 1) to determine whether there is a relationship between the paired sets of data in each hypothesis and, 2) to determine how statistically significant that relationship is, assuming that the relationship is not spurious (Schuyler & Cormier, 1996). The next section lists the four evaluation questions, two hypotheses, five descriptive variables, and the operationalized methods used to obtain the data for the study.

Questions, Hypotheses, and Descriptive Variables of the Study

This section is divided into three tiers. The first tier consists of presenting the question to be addressed by the study. These questions are labeled Q1, Q2, Q3, and Q4. Next, the hypothesis developed from Q1 and Q2 are listed below the questions. The hypotheses are specifically stated including operationalization of methods and statistical significance. These hypotheses are labeled H1 and H2. Finally, there are five descriptive variables labeled V1, V2, V3, V4, and V5 listed below the questions. Data are compiled on these descriptive variables and aggregated (See Table 1).

Q1. Does the quality of life improve for COS consumers?

H1. Consumers of the COS will demonstrate a statistically significant improvement (two-tailed, paired t-test; alpha = .05; and, n = 50) in daily functioning (as measured by the Behavior and Symptom Identification Scale [BASIS-32]) over a one year period (Eisen, Dill & Grob, 1994). The BASIS-32 contains 5 subscales that will be tested individually using two-tailed, paired t-test; alpha = .05; and, n=50.

Q2. What is the frequency of success or effectiveness that is achieved concerning the stated goals of COS programs in these specific areas:

a) Reduction of hospitalization in Geriatric population

H2. The geriatric consumer of the COS will demonstrate a statistically significant decrease (two-tailed, paired t-test, alpha = .05, n = 25) in hospitalization rate in the one year period of time since admission to the COS as compared to the hospitalization rate one year prior to COS treatment.

b) Flexibility of Interventions (meeting places, milieu of treatment, meeting times, availability of transportation)

V1. The data collected for this question is benchmark and will be aggregated and set up in frequencies (active files, n = 25; closed files, n = 25).

c) Family and Significant Other contacts

V2. The data collected for this question is benchmark and will be aggregated and set up in frequencies (active files, n = 25; closed files, n = 25).

d) Linkage to mental health services in Homeless population

V3. The data collected for this question is benchmark and will be aggregated and set up in frequencies (active files, n = 25).

Q3. What is the rate at which COS consumers obtain referral services?

V4. The data collected for this question is benchmark and will be aggregated and set up in frequencies (active files, n = 50).

Q4. What is the case composition and reasons for COS program discharges?

V5. The data collected for this question is benchmark and will be aggregated and set up in frequencies (closed files, n = 50).

Purpose and Importance of the Study for Social Work

The primary purpose of this study was to obtain data that will provide answers to the hypotheses developed in an external, confirmative, objectives-oriented program evaluation research design (Fitzpatrick et al., 2004; Worthern et al., 1997). This study was designed to establish an empirical database foundation for the specific use of informing COS social workers providing services to those consumers suffering from chronic mental illness as to the success of specific services that the COS implements. Second, it is the intent of the primary evaluator to contribute scholarly information to the knowledge development of social work practice within this area. Third, this study provides suggestions for improving COS direct social work practice to this population of consumers of this as a result of information obtained in this piece of research and a literature review. Fourth, the study provides benchmark information concerning the present rate of effectiveness of selected COS social work service delivery products. This benchmark data hopefully provides the impetus for overall improvements of the COS social work infrastructure. Fifth, this study provides data that is required in Joint Commission on Accreditation of

Table 1. Summary of Questions (Q), Hypotheses (H), and Descriptive Variables (V)

Question One (Q1) Does the quality of life improve for COS consumers?	Question Two (Q2) What is the frequency of success or effectiveness that is achieved concerning the stated goals of COS programs in these specific areas:	Question Three (Q3) What is the rate at which COS consumers obtain referral services?	Question Four (Q4) What is the case composition and reasons for COS program discharges?
Hypothesis One (H1) Consumers of the COS will demonstrate a statistically significant improvement in daily functioning.	Hypothesis Two (H2) The geriatric consumer will demonstrate a statistically significant decrease in hospitalization rate (compare one year prior to one year post admission to COS)	Descriptive Variable Four (V4) Referral service data	Descriptive Variable Five (V5) Demographic information and reason for discharge
	Descriptive Variable One (V1) Flexibility of Interventions		
	Descriptive Variable Two (V2) Family/Significant Other contacts		
	Descriptive Variable Three (V3) Linkage to mental health service in Homeless population		

Healthcare Organizations (JCAHO) reviews. Finally, data provided by this research will help support future grant applications for training, improving, continuing, and expanding social work service to this group of disenfranchised consumers. The multiple purposes of this study are in direct keeping with the Council of Social Work Education's overall purpose of social work: "The promotion, restoration, maintenance, and enhancement of the functioning of individuals, families, groups, organizations, and communities by helping them to accomplish tasks, prevent and alleviate distress, and use resources" (Council on Social Work Education, 1992:97, p. 135)

Definition of Terms

The following is a list of definition terms used within the context of this research study.

1) Consumer: An individual that uses any variety of mental health services (medication, hospitalization, therapy, substance abuse services, shelters). This definition is not meant to imply that a consumer has choices over services or the power to choose which services they receive (U.S. Department of Health and Human Services, 1999).
2) Consumer of the COS: An individual that is enrolled in the COS and has a Grady Health System medical record number.
3) Chronic Mental Illness: Also considered 'severe and persisting' problems with thinking, mood, or behavior (or any combination listed) associated with personal distress, risk of death, pain, disability or loss of freedom (American Psychiatric Association, 1994). For the purpose of this study, the term 'chronic/severe' will be used in to discuss the population being evaluated.
4) Homeless: The McKinney Act (P.L. 100-77, sec 103(2)(1), 101 sat. 485 (1987)) defines a homeless person as: An individual who (1) lacks a fixed, regular, and

> adequate nighttime residence and (2) has a primary nighttime residence that is (a) supervised, publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill), (b) an institution that provides a temporary residence for individuals intended to be institutionalized, or (c) a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (The Stewart B. McKinney Homeless Act, 1987; U.S. Department of Housing and Urban Development, 1995).

Strengths and Limitations of the Research

The major strength of this research is built into the process by which the researcher became familiar with the subjects, the procedures of service delivery of the program, and the familiarity with the record keeping process. Encapsulated in this strength is the twenty years of expertise that the researcher has in providing care and treatment to this specific population. The COS requested this evaluation, in part, due to their knowledge of the researcher's practice wisdom in this area. Second, the method by which the data were collected strengthens the statistical inferences. In order to minimize recording error, data were collected through a process of recording information and then reviewing the recorded information approximately one week later to discover any errors in data collections. Next, the length of time the information in the records were studied (six months and one year) was used in an attempt to eliminate any short term errors and established a pattern of documentation for the data gathered. Finally, only documented data on consumers that had been treated in the program for a minimum of 1 year were considered for the two major hypotheses.

The most serious limitation of this study is the lack of control characteristically found in an experimental design. Because of this, even with a rejection of Ho, only correlations, not causality, can be made concerning the data (Schuyler & Cormier, 1996). This lack of control also makes the use of generalization very limited. Additional limitations are inherent in the study due to potential primary record keeping errors (by clinicians) that could lead to an error in the interpretation of the data. A final limitation is the sample size (N = 50 for H1, and N = 25 for H2). Despite these limitations, the worthiness and merit of determining efficacy of service delivery to this frail population of consumers should offset these issues.

CHAPTER 2

REVIEW OF THE LITERATURE

The public opinions and resulting policies for the provision of care for persons suffering from various forms of mental illnesses has gone through a series of philosophical and policy structural changes in America since the turn of the 19th century (Grob, 1994). Although there are consumers that lead productive and secure lives, there are also many consumers that live in abject poverty (Interagency Council on the Homeless, 1999). Social workers have in the past, and must continue in the future to insert themselves into policy development, advocacy, care, and treatment of persons suffering from chronic mental illness. Persons suffering from chronic mental illness may be frail and marginalized as a result of a ruthless and cyclic disease process. Without additional resources, family support, and a responsive social welfare system, the environmental insult of oppression is added to the burden of those persons suffering from chronic mental illness. Options and choices are lost as consumers are reduced to homelessness and its plaguing and often fatal problems. Homelessness is a social condition that has received great attention in both the world of research and the politics (Grob, 1994; Gruenberg & Archer, 1979; Interagency Council on the Homeless, 1999; NCH Fact Sheet #18, 1999). The homeless individual epitomizes the culmination of poverty, lack of education, lack of social skills, severe mental illness, substance abuse, and severed family ties that fall far below the level that is acceptable for a human being to thrive.

The review of literature for Chapter Two is set up to first provide a foundation for understanding the environment in which this study took place. First, a discussion of mental illness and the most common associated problems for those that are homeless and suffering from mental illness will be reviewed. Then, a review of the literature outlining the history behind the policy developments of the four reform eras that lead to the socially constructed homeless population of consumers suffering from chronic mental illness (see Table 1. Reform Eras of Mental Health Care in America, page 50) is outlined to bring the reader into the present state of affairs. Next, the McKinney-Vento Act of 1987 – which is to date the only federal act that provided care to the homeless – is presented and discussed. Following information about the federal act is informative current research concerning the demographic makeup of this population. Finally, a scholarly discussion of service delivery to the homeless and a presentation of this researchers' Best Practices Service Delivery Model for the homeless will complete this chapter.

Defining Mental Illnesses/Disorders

The complexities of mental illnesses (also referred to as 'mental disorders') are not simply stated nor should they remain a definitive condition. Mental illnesses/disorders are – arguably by necessity – a multi-faceted concept. There are many definitions, ranging from the technical to layman's terms, for the conditions and symptoms of mental illnesses/disorders. A simple and very applicable definition of mental illness/disorders is provided by the U. S. Department of Health and Human Services [HHS] in *Mental Health: A Report of the Surgeon General* (1999). This reports (U.S. Department of Health and Human Services, 1999) defines mental illnesses/disorders as "health conditions that are characterized by alterations in thinking, mood, and behavior (or some combination thereof) associated with distress and/or impaired functioning" (p. 5). Further expanding on this definition, the DSM-IV-TR (APA, 2000) offers a consistent, flexible and enduring description of mental illnesses/disorders that is considered the professional benchmark for the defining mental illnesses/disorders:

> . . . each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., painful symptom) or disability (i.e., impairment in one or important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. (p. xxxi)

As expressed by this definition, there are several components to developing the modern construct of mental illnesses/disorders. The first component is a pattern of significant clinical behaviors; the second component is a significant level of distress or disability; and, the third component is a significant increase in risk factors. It is the critical combination of these three constructs evaluated within social and cultural environment of the individual that makes up a mental illness/disorder as defined by the DSM-IV-TR (APA, 2000) and used to diagnose those individuals suffering from mental illnesses/disorders.

Mental illnesses/disorders are a complex and serious disease process. In present times, mental illnesses/disorders are defined within a matrix that combines the biological input, the psychological impact, and the social and cultural influences. Through the process of research and education, the understanding has emerged that mental illnesses/disorders are not what a person is; this is a condition they have.

Mental illnesses/disorders vary in chronicity and severity. The chronicity may vary from days to weeks, months to years, or intermittently over the course of a lifetime. The severity of illness may vary from mild to severe with psychotic features. The individuals that are discussed here and involved in this study are considered to have developed chronic and severe forms of mental illnesses/disorder. These types of mental disorders are referred to as chronic/severe in the remainder of this study

As the actual numerical count of homeless people vary from census to census, the numbers of those homeless who are chronically/severely mentally ill varies even more. The federal standard for defining the homeless has been set in the Stewart B. McKinney Homeless Assistance Act (PL 100-77, sec 103(2)(1), 101 sat 485). In its opening sentence, the Act (National Institute of Mental Health, 1992) refers to the homeless person as someone "who lacks a fixed, regular, and adequate nighttime residence . . ." (p.7). According to the 1992 Department of Health and Human Services census, there were 600,000 homeless Americans on any given night in urban areas (National Institute of Mental Health, 1992, p. 7). The estimate for those with chronic/severe mental illness varies from 30% to as high as 70% (National Institute of Mental Health, 1992, p. 7). The Task Force points out that of the 4 million people in the United States are estimated to have chronic/severe mental illness, with 1/20 of these persons not having a stable home (National Institute of Mental Health, 1992, p. 18). Figure 1 provides a graphic representation of the homeless individual that suffers from chronic/severe mental illness as compared to the general population of persons suffering from chronic/severe mental illness.

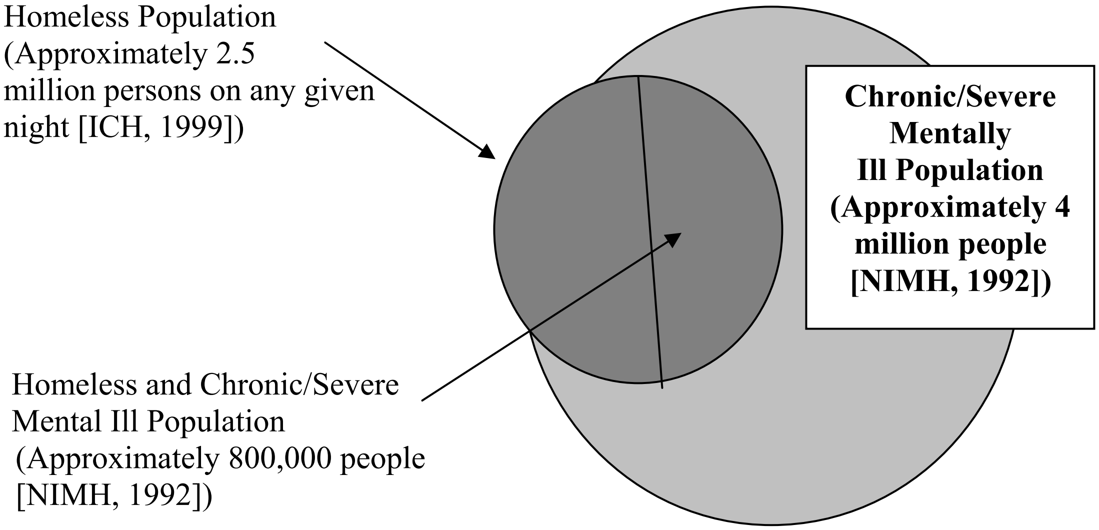

Figure 1.The Homeless Individual and Chronic/Severe Mental Illness

Although the homeless person in this population may suffer from many different forms of mental illnesses/disorders, there are several mental illnesses/disorders that appear to be a consistent and common variable. The next section will provide information on some of the more common forms of mental illnesses diagnosed among the homeless population.

Schizophrenia and Other Psychotic Disorders

Schizophrenia is a serious mental illness that is estimated to affect 1% of the human race (Kaplan & Sadock, 1988). Schizophrenia erodes the cognitive processes, making it difficult to maintain problem – solving abilities, negotiate relationships, and continue normal human development. This illness is heavily weighted when the burden of lifetime care is factored in. It is difficult to maintain a job – hence the potential loss of a stable living condition, relationships, retirement money, health insurance, and ability to purchase medication. It is the reality of those persons with schizophrenia that they often run out of resources and become homeless.

This group of mental illnesses/disorders are characterized by at least two of the following symptoms for at least a one month duration (APA, 2000): 1) delusions, 2) hallucinations, 3) disorganized speech, 4) grossly disorganized or catatonic (stiff or rigid) behavior, and 5) negative symptoms (flatten affect, alogia [poverty of speech (U.S. Department of Health and Human Services, 1999)], or avolition [difficulty or inability to sustain goal-directed behavior (U.S. Department of Health and Human Services, 1999)]).

Schizophrenia and other psychotic disorders are also punctuated by a markedly noticeable drop in a prior (pre-morbid) level of functioning in one or more areas of work, interpersonal relationships, or self-care (APA, 2000). These disturbances should last at least six months before these serious mental illnesses/disorders are considered a possibility. Schizophrenia and other psychotic disorders, like any serious and chronic disease process, often results in a disruption of the brain’s executive functions; rendering the individual critically impaired in the areas of economic self-sufficiency, adequate social skills, and stable psychological well-being (U.S. Department of Health and Human Services, 1999).

The estimations of prevalence of schizophrenia and other psychotic disorders vary, depending on size, setting, methodology, and the application of diagnostic criteria in the study. On average, these disorders account for 1% - 2% of the population (APA, 2000) with a 1- year prevalence rate for adults (ages 18 to 54) being set at 1.3% (Gottesman, 1991).

Paramount to the reduction in severity of symptoms, recidivism rate, and recovery of persons suffering from schizophrenia and other psychotic disorders is early diagnosis and consistent treatment. The following four studies have found that treatment with antipsychotic medications at early onset appears to result in improved long-term outcomes (Lieberman, Koreen, Chakos, Sheitman, Woerner, Alvir, & Bilder, 1996; Wyatt, Green, & Tuma 1997;

Wyatt, Damiani & Henter, 1998; Wyatt & Henter, 1998). Rehabilitation after onset also demonstrates improved long-term outcomes on the course of Schizophrenia and other psychotic disorders (Awad, Voruganti & Heslgrave, 1997; Hafner & an der Heider, 1997; Lieberman et al. 1996;). The issues of early and consistent treatment and rehabilitation are serious and intuitively impossible for the homeless population to achieve. Lacking income, health insurance and housing stability, the prognosis for adequate and stable treatment is inadequate for this population (Interagency Council on the Homeless, 1999; National Institute of Mental Health, 1992; U.S. Department of Health and Human Services, 1999).

Mood Disorders

Mood Disorders are best described as a greater than normal change in the way an individual feels coupled with the behavioral results associated with those feelings. Although there are several variances in mood disorders, according to *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services, 1999), "The disorder most closely associated with persistent sadness is major depression, while that associated with sustained elevation or fluctuation of mood is bipolar disorder." (p. 42). This report (U.S. Department of Health and Human Services, 1999) also provides the following list of the most common signs and symptoms displayed by a individual suffering with depression: 1) persistent sadness or despair; 2) insomnia (or hypersomnia); 3) decreased appetite; 4) psychomotor retardation; 5) anhedonia (inability to feel pleasure); 6) irritability; 7) apathy, poor motivation, or social withdrawal; 8) hopelessness; 9) poor self-esteem; and, 10) suicidal ideations. In addition, the following are signs and symptoms most commonly displayed by an individual suffering with mania (U.S. Department of Health and Human Services, 1999): 1) persistently elevated or euphoric mood; 2) grandiosity; 3) psychomotor agitation; 4) decreased need for sleep; 5) racing thoughts, inability to stay on track; 6) poor judgment and impaired impulse control; and, 7) rapid or pressured speech.

The impact of mood disorders on an individual's well-being and level of functioning is staggering. Murray and Lopez (1996) reported that mood disorders are a major culprit in contributing to world wide disability with depression in the top position and bipolar (both depression and mania) in the top 10. According to the Surgeon General's report, *Call to Action on Suicide* (U.S. Department of Health and Human Services, 1999), seven percent of Americans suffer from mood disorders each year. This statistic is further punctuated by the additional information that 20 to 35 percent of deaths by suicide are committed by persons suffering from mood disorders (Angst, J., Angst, F. & Stassen, 1999). Mood disorders further exacerbate the propensity of a co-morbid substance abuse disorder. The frequency of a person suffering from a mood disorder to also have a substance abuse disorder is between 24 to 40 percent (Meridangas, Mehta, Molnar, Walters, Swendsen, Aguilar-Gaziola, Bijl, Borges, Caraveo-Anduaga, Dewit, Kolody, Vega, Wittchen & Kessler, 1998). Three additional studies have also found that severe or prolonged stress experienced by homeless individuals may trigger mood disorders (Brown, Harris & Hepworth, 1994; Frank, Anderson, Reynolds, Ritenour & Kupfer, 1994; Ingram, Miranda & Segal, 1998). These findings support the practice wisdom of this researcher and the belief of professionals serving the homeless community in this study - that living 'rough on the streets' (no stable shelter, consistent supply of food, and civil human contact) triggers episodes of mental illness – both in individuals with a pre-existing condition of mental illness and individuals that have no previous history of mental illness.

Substance-Related Disorders

Substance-related disorders consist of the disorders correlating to the consumption of a drug of abuse, side effects of a medication, and toxin (poisonous substance) exposure. The DSM-IV-TR (APA, 2000) divides substances into 11 classifications or groups as follows: 1) alcohol; 2) amphetamine or similarly acting sympathomimetics; 3) caffeine; 4) cannabis; 5) cocaine; 6) hallucinogens; 7) inhalants; 8) nicotine; 9) opioids; 10) phencyclidine (PCP) or similarly acting arylcyclohexylamines; and, 11) sedatives, hypnotics, or anxiolytics.

Substance-related disorders are classified into two separated groups, primarily by symptoms and behaviors concerning the consumption of substances. The first group is Substance Use Disorders. This group consists of the categories of dependence and abuse. According the DSM-IV-TR (APA, 2000) dependence is defined as "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems" (p. 192). The DSM-IV-TR (APA, 2000) defines abuse as "a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances" (p. 198).

The second group of substance-related disorders is grouped under Substance-Induced Disorders, and consists of the following categories (APA, 2000): 1) substance intoxication; 2) substance withdrawal; 3) substance-induced delirium; 4) substance-induced persisting dementia; 5) substance-induced persisting amnesic disorder; 6) substance-induced psychotic disorder; 7) substance-induced mood disorder; 8) substance-induced anxiety disorder; 9) substance-induced sexual dysfunction; and, 10) substance-induced sleep dysfunction.

Substance-related issues are self-reported in epidemic (widely prevalent) proportions among the homeless. The Interagency Council on the Homeless (1999) provides self-reported percentages of a 58% life-time problem with drugs and a 62% life-time problem with alcohol among the 2,938 homeless persons surveyed. In addition, secondary issues associated with substance abuse (i.e., domestic violence, mental health stability, and incarceration) are also reported in substantially higher among the homeless than in the standard U.S. population rates (Interagency Council on the Homeless, 1999).

Compounding the above mentioned problems is the additional research findings that the incidence of co-morbid substance abuse-dependence for those individuals that have schizophrenia is 47% (Regier, Farmer, Rae, Locke, Keith, Judd & Goodwin, 1990). In addition, this research also reports the occurrence of alcoholism with any lifetime mental disorder diagnosis within this study is 22.3% - the rate of alcoholism with no history of mental disorder is 11.0% (Regier et al. 1990). Furthermore, this research reports that 14.7% of those persons with a lifetime mental disorder also abuse or are dependant on other drugs – the rate of drug abuse-dependence with no history of mental illness is 3.7% (Regier et al. 1990). All these additional problems exponentially compound the problems associated with the care and treatment of persons suffering from chronic mental illness.

Personality Disorders

The definition of a Personality Disorder (APA, 2000) is “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (p. 685).

The main focus in the process of diagnosing an individual as having a Personality Disorder is the establishment of maladaptive behaviors exhibited in a variety of social and personal situations. Personality Disorders can and often co-exist with substance abuse disorders (North & Smith, 1993). Regier’s study (1990) reports, for those individuals with a diagnosis of antisocial personality disorder, some form of substance abuse is identified in 83.7% of this group. Co-existing disorders complicate treatment, increase health risks factors, and compound housing issues for the homeless (Dixon & Osher, 1995; Gonzalez & Rosenheck, 2002; North & Smith, 1993).

Personality Disorders are combined into three groups based on behaviors. The groups are as follows (APA, 2000): 1) Cluster A: Paranoid, Schizoid, and Schizotypal; 2) Cluster B: Antisocial, Borderline, Histrionic, and Narcissistic; and, 3) Cluster C: Avoidant, Dependant, and Obsessive-Compulsive. Individuals diagnosed with Cluster A Personality Disorders (Paranoid, Schizoid, and Schizotypal) present as odd acting or having unusual thoughts and behaviors. They do not make friends easily and are highly suspicious of others. Individuals diagnosed with Cluster B Personality Disorders (Antisocial, Borderline, Histrionic, and Narcissistic) present with unpredictable behavior, extreme mood swings, impulsivity, and dramatic displays in temperament. These individuals appear to manipulate and thrive in chaotic situations with reduced capacity to anticipate consequences. Individuals diagnosed with Cluster C Personality Disorders (Avoidant, Dependant, and Obsessive-Compulsive) display an excessive amount of anxiety. These individuals often seem driven in a endless cycle of behaviors aimed at reducing internal fears or anxieties that appear unusual or excessive.

Odd and bizarre behaviors (as evidenced in personality disorders) are under strong scrutiny when the caustic living environment that the homeless face are factored in (Napier & Whitaker, 1978, p.53; Stoudemire, 1990, p.91). There is reasonable belief and support within the treatment community that the avoidance, aggressive, and antisocial behaviors found in regularity among the homeless are based on the coping and adaptive mechanisms of humans to make changes in behavior based on environmental feedback (Bazelon Center for Mental Health Law, 2001; Napier & Whitaker, 1978; Stoudemire, 1990; Treatment Advocacy Center, 2002).

Historical Perspective of Mental Health Reform in America

The late 1800s and early 1900s saw the development of the first of four reform movements shaping the care and treatment of persons suffering from mental illness in the United States (Goldman and Morrissey*,* 1985; Grob, 1994; Morrissey & Goldman, 1984; U.S. Department of Health and Human Services, 1999). The first era, known as 'moral treatment', was championed by such early social work reformist as Dorothea Lynde Dix and Horace Mann. These individual advocated for compassionate care, understanding concerning the situation of those suffering with mental illness, respite, and rehabilitation. States built either public or private asylums (a place offering protection or safety) for the early treatment of mental illness in a controlled environment. Early treatment objectives were primarily center on the restoration of mental health and prevention from having a chronic mental condition (Grob, 1994; U.S. Department of Health and Human Services, 1999). This era demonstrated some success in the area of restoration, but made no impact on the prevention of chronic mental illness (U.S. Department of Health and Human Services, 1999). The asylums became seriously over crowded with persons suffering from chronic mental conditions and financial constraints bound the ability to provide therapeutic and custodial care. The era of moral and compassionate care ended in disillusionment.

The second era, know as 'mental hygiene', began shortly after the end of the Civil War. This reform was shaped by newly developing concepts of public health, scientific medicine, and the tenants of social progressivism fueled by the work of Dr. Adolf Meyer, Dr. William James and author Clifford Beers (*The Mind That Found Itself)* (Goldman and Morrissey*,* 1985; Grob, 1994; Morrissey & Goldman, 1984; U.S. Department of Health and Human Services, 1999). The belief that mental illness was treatable and pre-morbid restoration was possible, especially with early intervention, was again revived. This era saw the creation of the National Committee for Mental Hygiene (the name was later changed to National Mental Health Association [NMHA]) that provided an advocacy and leadership role in the policy decisions enacted for the care and treatment of persons suffering from mental illness. Early treatment as a preventative measure was still espoused. This philosophy materialized in the form of outpatient clinics and "psychopathic hospitals" (Morrissey & Goldman, 1984). The "psychopathic hospital" was "an acute treatment facility affiliated with university training and research institutes" (Morrissey & Goldman, 1984). The focus of the 'mental hygiene' era was on the treatment and care of persons suffering from dementia, alcoholism and hereditary factors of mental illness (Grob, 1983; Sicherman, 1980; Rothman, 1980). Outpatient clinics offered help in the areas of behavior management of difficult children, criminal and prostitution reform and issues dealing with welfare and individual productivity development (Grob, 1983; Sicherman, 1980; Rothman, 1980). Again, the initial focus on prevention of chronic mental illness diminished with repeated failures. Psychiatric beds remained filled with consumers suffering from chronic mental conditions while over-all treatment was reduced at times, to poor custodial care. The New York State Care Act of 1890 set into law the guidelines for state government fiduciary responsibility on behalf of consumers suffering from mental illness. As a result of this policy change, between the years of 1903 and 1950, state mental health hospitals experience a 240 percent increase (from 150,000 to 512,500 persons) in concert with the decline of local almshouses (Morrissey & Goldman, 1984). State mental health hospitals were resigned to providing long term custodial care for primarily the poor and disabled in an era often referred to as the Dark Ages of mental health (Morrissey & Goldman, 1984).

The third reform movement gained momentum during the years of World War II. Several major critical events propelled the ‘community mental health’ era forward. First, new short term therapy techniques were developed that reduced the possibilities of consumers being removed from their homes and hospitalized at remote state facilities. Second, new psychosocial models for rehabilitation were also being implemented with those consumers suffering from more chronic mental health conditions. Finally - the driving force of this era - the development of psychotropic medications (chlorpromazine or thorazine) would allow for the discharge of many consumers from long term facilities (Talbot, 1982; Treatment Advocacy Center, retrieved Oct. 2002). There were also some outpatient clinics and acute crisis beds available at limited medical facilities to serve the ever growing number of consumers being discharged from state facilities (Linn, 1961; Morrissey & Goldman, 1984).

Several major federal policy pieces were also enacted to promote the ‘community mental health’ era and further the development of treatment and the knowledge base concerning mental illness. The National Mental Health Act of 1946 provided for the nationwide development of research through the National Institute of Mental Health. The Joint Commission on Mental Illness and Health was set into motion by The Mental Health Study Act of 1955. In a very powerful, final report issued by the Joint Commission in 1961, *Action for Mental Health*, the proposal for ‘community mental health’ care was presented (Joint Commission on Mental Illness and Health, 1961). President John F. Kennedy followed the recommendations of this report, signed for the creation of the Community Mental Health Act of 1963 and set into motion the development of a nationwide system of community mental health centers [CMHC] (Joint Commission on Mental Illness and Health, 1961). The Treatment Advocacy Center (retrieved October 2002) provides this summary of issues surrounding deinstitutionalization:

> In 1965, the federal government specifically excluded Medicaid payments for patients in state psychiatric hospitals and other "institutions for the treatment of mental diseases," or IMDs, to accomplish two goals: 1) to foster deinstitutionalization; and 2) to shift the costs back to the states which were viewed by the federal government as traditionally responsible for such care. States proceeded to transfer massive numbers of patients from state hospitals to nursing homes and the community where Medicaid reimbursement was available (p. 2).

Although the creation of CMHCs shifted the responsible party providing care from the state hospitals to the local mental health centers, this financial policy shift in retrospect, did not provide for the treatment and support needed by the consumer suffering from chronic mental illness (Bassuk & Gerson, 1978; Chu, and Trotter, 1974; Rose, 1979; Gruenberg & Archer, 1979). From 1955 to 1980, there was a 75 percent reduction in the census of state mental hospitals (approximately 420,000 beds) where consumers were discharge back to communities (Morrissey,1982). CMHCs responses to deinstitutionalized consumers ranged from being unable to unwilling to care for this chronic population (Goldman & Morrissey, 1985; Morrissey & Goldman, 1984). In theory, policies of deinstitutionalization defended the right of the consumer to live in the 'least restrictive environment' while maintaining contact with their community (Bazelon Center for Mental Health Law, 2001)). In reality, the rapid downsizing of state mental hospitals, married to severe federal financial constraints and inadequate planning for transition of care to CMHCs, created a sizeable population of chronically mentally ill near homeless or homeless people (Cohen & Thompson, 1992; U.S. Department of Health and Human Services, 1999; Wolff & Stuber, 2002). Deinstitutionalization was provided further momentum in the courtrooms of the nation. State laws concerning treatment and commitment processes were change to “such and extent that it is now virtually impossible to assist in the treatment of psychotic individuals unless they first pose extreme an imminent danger to themselves or society” (The Treatment Advocacy Center, p. 1). Goldman and Morrissey (1985) provided this caustic view of the third era in mental health reform, “Community mental health brought mental patients ‘home’; deinstitutionalization left them homeless.” (p. 729).

The current fourth era of mental health reform embraces the mainstream ‘community support’ model of deinstitutionalization with a focus on humanitarian care, support, and rehabilitation for the consumer within the community (Goldman & Morrissey, 1985; Morrissey & Goldman, 1984; U.S. Department of Health and Human Services, 1999). An import philosophical change in the fourth reform movement was a focus on long-term care of persons with chronic mental conditions. The ‘community support’ program was initially federally funded by a NIMH 3.5 million dollar block grant to 19 states. The present reform era was legitimized by the passing of the Mental Health Systems Act of 1980 (Morrissey & Goldman, 1984). According to Morrissey and Goldman (1984), the Mental Health Systems Act . . .

> enabled states and local agencies to establish community support systems and other community-based mental health services with federal funding. Thus in 1980 it appeared that the community support movement had succeeded in ushering in a major reform in mental health services for chronically mentally ill persons (p. 790).

Although the ‘community support’ reform era began, as did the previous three reforms, with a theoretically hopeful start, the nemesis of the current reform is the familiar specter of economic and fiscal budget cuts (Goldman & Morrissey, 1985; Morrissey & Goldman, 1984; U.S. Department of Health and Human Services, 1999). The direct result of policy changes, budget cuts and financial reallocations placed a tremendous burden on CMHCs. Goldman and Morrissey (1985) state, “Mental health centers failed to meet the needs of acute and chronic patients discharged in increasing numbers from public hospitals. Homelessness and indigency were predictable outcomes for many” (p. 729). The following table (used with permission, Goldman, 2003) summarizes the four reform eras by listing the movement name, the setting in which the movement primarily took place, the time frame, and the main focus of the movement.

Table 2. Reform Eras of Mental Health Care in America

Reform Movement	Setting	Time Frame (Approximate)	Focus of Reform
Moral Treatment	Asylums	1800-1850	Early Treatment
Mental Hygiene	Mental hospitals, out patient clinics	1890-1920	Prevention Scientific approach
Community Mental Health	CMHCs	1955-1970	Deinstitutionalization Reintegration
Community Support	Local Communities	1975-present	Social welfare, long-term community care

Sources: Goldman & Morrissey, 1985; Morrissey & Goldman, 1984; U.S. Department of Health and Human Services, 1999. Used with permission, Goldman, January 2003.

The willingness to care for the homeless person resided within each individual state. The states, in turn, disbursed the financial support in varying degrees – dependant on the political and financial status, within each state. This laizze fare approach to care for the homeless continued until 1987 with the passing of the McKinney-Vento Act. The following is a summary of this federal humanitarian aid that remains the only act of its kind.

The McKinney-Vento Act

The 1987 Stewart B. McKinney Homeless Assistance Act, (P.L. 100-77, 1987) named posthumously for its chief sponsor, remains to date, the only federal legislative initiative responding to the needs of homeless individuals and families with children. The McKinney Act (later named the McKinney-Vento Act) originally contained nine titles and twenty programs providing a comprehensive range of services to homeless persons. These programs focus on a variety of assistance to the homeless including but not limited to: 1) provisions for emergency shelters; 2) transitional housing; 3) job training; 4) primary health care; 5) mental health care; 6) substance abuse treatment; 7) child care; 8) primary education; 9) some permanent housing; and, 10) some homelessness prevention (NCH Fact Sheet # 18;1999; U.S. Department of Housing and Urban Development [HUD], 1995). The McKinney-Vento Act has been modified and amended four times since its conception (1988, 1990, 1992, and most recently in 1994), expanding and strengthening the provisions of the original nine titles. Brief summaries of the nine titles are as follows (NCH Fact Sheet # 18, 1999):

1) Title I of the McKinney-Vento Act defines homelessness and lists six findings concerning homelessness at the time the act was compiled by Congress.

   The McKinney Act (P.L. 100-77, sec 103(2)(1), 101 sat. 485 (1987)) defines a homeless person as: An individual who (1) lacks a fixed, regular, and adequate nighttime residence and (2) has a primary nighttime residence that is (a) supervised, publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill), (b) an institution that provides a temporary residence for individuals intended to be institutionalized, or (c) a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (The Stewart B. McKinney Homeless Act of 1987, U.S. Department of Housing and Urban Development [HUD], 1995)

2) Title II of the McKinney-Vento Act establishes the functions of the Interagency Council on the Homeless [ICH] as an independent entity currently comprised of the heads of 18 federal agencies and an executive director that oversee service provisions (Interagency Council on the Homeless, 1999).

    a) Department of Housing and Urban Development
    b) Department of Health and Human Services
    c) Department of Agriculture
    d) Department of Commerce
    e) Department of Defense
    f) Department of Education
    g) Federal Emergency Management Agency
    h) Department of Energy
    i) Department of Interior
    j) Department of Justice
    k) Department of Labor
    l) Social Security Administration

  m) Department of Transportation
  n) Department of Veterans Affairs
  o) Corporation for National and Community Service
  p) General Services Administration
  q) Office of Management and Budget
  r) The United States Postal Service
  s) Philip F. Mangano, Executive Director

3) Title III of the McKinney-Vento Act provides for the Emergency Food and Shelter Program administered by the Federal Emergency Management Agency [FEMA] (NCH Fact Sheet # 18,1999).

   According to the ICH, the National Survey of Homeless Assistance Providers and Clients [NSHAPC], the first landmark study entitled "Homelessness: Programs and the People They Serve," indicates there are approximately 9,000 food pantries, 5,700 emergency shelters, 4,400 transitional housing programs, 3,500 soup kitchens and/or distributors of meals, 3,300 outreach programs and an estimated 3,100 voucher distribution programs (Homelessness: Programs and the People They Serve. Retrieved October, 2002).

4) Title IV of the McKinney-Vento Act provides for multiple programs administered by the Department of Housing and Urban Development [HUD]. These transitional housing programs include the Emergency Shelter Grant [ESG] program (an expansion of the original 1986 Homeless Housing Act), the Supportive Housing Demonstration Program, Supplemental Assistance for Facilities to Assist the Homeless, and Section 8 Single Room Occupancy Moderate Rehabilitation. The Office of Policy Development and

Research, U.S. Department of Housing and Urban Development estimates the Emergency Shelter Grant (ESG) serves 2.8 million individuals and 1.1 million families in one year (U.S. Department of Housing and Urban Development [HUD], 1995). These services include provisions for nighttime shelter, meals, counseling, or help with enrolling for entitlements.

5) Title V of the McKinney-Vento Act regulates federal agencies concerning the availability of surplus federal property (buildings and land) to assist homeless people. Although there are no firm estimates of the incidence of homelessness (those individuals that are homeless on any single day), approximations from several different sources show that between 2.5 and 3.5 million people (children included) are homeless at least one night of any given year (Burt, Aron, Lee, 2001; Culhane, Dehowski, Ibanes, Needham, Macchia, 1994; HUD, 1995; Link, Susser, Stueve, Phelan, Moore, Struening, 1994; Link, Phelan, Bresnahan, Stueve, Moore, Susser, 1995.)
6) Title VI of the McKinney-Vento Act directs the Department of Health and Human Services to provide an array of programs designed to provide health care services to the homeless. These health care service programs include: 1) Health Care for the Homeless; 2) Community Mental Health Services; and, 3) two initiative programs designed to provide mental health and substance abuse treatment services for the homeless.

Mental Illness and substance abuse are serious problems faced by the homeless. Approximately 200,000 homeless persons suffer from mental illness, about 300,000 use drugs or alcohol, and 86% of all homeless persons report a problem with mental illness and/or substance abuse during their lifetime (Satel, 1994; Interagency Council on the Homeless, 1999).

7) Title VII of the McKinney-Vento Act contains four education/training programs: the Adult Education for the Homeless Program, the Education of Homeless Children and Youth Programs, the Job Training for the Homeless Demonstration Program, and the Emergency Community Services Homeless Grant Program.

   Homeless adults are less educated than their housed adult counterparts. Thirty-eight percent of homeless persons have less than a high school education while 25% of their housed counterparts dropped out of high school (Interagency Council on the Homeless, 1999).

8) Title VIII of the McKinney-Vento Act expands the Food Stamp program to include participation by homeless persons, and also expands the Temporary Emergency Food Assistance Program administered by the Department of Agriculture.

   Homeless persons report that they are hungry on a regular and consistent basis. At least 40% say they did not eat for one day--due to lack of resources--while 39% say they were hungry and did not have enough food to eat during the past 30 days-- also due to lack of resources (Food and Consumer Service, 1999).

9) Title IX of the McKinney-Vento Act expands the Veterans Job Training Act. Veterans comprise 23% of the homeless. In addition, 98% of this group is male with almost half being Vietnam veterans and the other half serving after the Vietnam era (Interagency Council on the Homeless, Highlights Report, retrieved October, 2002).

To date, the McKinney-Vento Act remains the foundation and impetus for the laws and programs designed to address the problems faced by various groups of homeless and near-homeless individuals and families. While the current nine titles and fifteen programs are specifically targeted for homeless relief, the next generations of McKinney-Vento Act reforms are being developed with the hope of prevention as the prevailing motivation of design (NCH Fact Sheet # 18, 1999).

Evaluations of McKinney-Vento Act Titles and Programs. Since the inception of the McKinney-Vento Act in 1987, several large-scale government-funded evaluations and benchmark data gathering of individual titles, specific programs and the homeless clients have occurred. The first national study concerning homelessness was conducted in 1987 by the Urban Institute (Burt & Cohen, 1989). This study was limited to information obtained by survey method in shelters and soup kitchens in large U. S. cities with a census of 100,000 or more (Interagency Council on the Homeless, Highlights Report, retrieved October, 2002). This report estimated the number of metropolitan homeless during that time, gathered some demographic and trait information concerning different groups of homeless persons, and reported on the capacity of soup kitchens and shelters to serve these homeless clients (Burt & Cohen, 1989; National Law Center On Homelessness and Poverty, 2002).

In 1992, Congress requested a report from the secretary of HUD on the results of the McKinney-Vento Title IV programs administered by this department. The *Stewart B. Mckinney Homeless Programs PD & R Report to Congress* was conducted using a standardized survey administered to Title IV programs. The report was published in January 1995 *(*U. S. Department of Housing and Urban Development, 1995) and listed the evaluation of the following six programs administered by HUD under Title IV of the McKinney-Vento Act: Emergency Shelter Grants Program [ESG]; Supportive Housing Demonstration Program [SHDP]; Section 8 Moderate Rehabilitation Assistance for Single-Room Occupancy Dwellings [SROs]; Shelter Plus Care [S+C]; Supplemental Assistance to Facilities to Assist the Homeless [SAFAH]; and Single Family Property Disposition Initiative [SFPDI] (HUD, 1995). This 1995 *PD&R Report* summarizes the following problems associated with Title IV of the McKinney-Vento Act (U.S. Department of Housing and Urban Development [HUD], 1995).

> However, the sheer number and variety of HUD's McKinney Act programs have sometimes created barriers to their efficient use. Differences among target populations, eligible activities, application requirements, and selection criteria for the various programs have made this assistance difficult to obtain and coordinate. Overlapping sets of regulations and reporting requirements have further complicated grant administration. Moreover, the unpredictability of competitive grants, appropriation levels, and the varying lengths of grant awards have frustrated attempts to implement longer term, comprehensive strategies for eliminating homelessness. (p. 1)

Despite these comments concerning HUD's administration of Title IV programs, the U.S. Department of Housing and Urban Development [HUD], Division of Program Evaluation in the Office of Policy and Development and Research (1995) found that, "In spite of challenges and complexities, McKinney grantees have achieved measurable results toward ending or preventing homelessness" (p. 3).

In 1999, the ICH issued its findings of the National Survey of Homeless Assistance Providers and Clients [*NSHAPC*], also prepared by the Urban Institute (Interagency Council on the Homeless, 1999). This is the second such national survey of the structure of homeless assistance providers (faith-based, secular, local and government funded) and the homeless clients that use these services. It is an expansion of the 1987 sister survey also prepared by the Urban Institute (Interagency Council on the Homeless, 1999) that …

> was designed to provide up-to-date information about the providers of assistance to homeless people, the characteristics of those who use the services that focus on homeless people, and how this population has changed in the metropolitan areas since 1987. (p. xiv)

This landmark survey verifies the diversity of the homeless populations, the limited income and resources of those populations, and the severity and complexity of the needs of homeless clients; however, it was not designed to count the homeless (Interagency Council on the Homeless, 1999).

The most recent report concerning the McKinney-Vento Act programs was compiled by HUD in May of 2002 by evaluation of the Continuums of Care [CoC] process initiated by HUD. This benchmark study provides the first organized evaluation of the CoC process instituted by HUD from 1993-1995 to stimulate comprehensive planning and improve structural development of services provided to the homeless at the community level (U.S. Department of Housing and Urban Development [HUD], 2002). The study supported the merits of multi-agency collaboration and long term planning. In addition, reaffirmation concerning severe lack of affordable housing and extreme difficulty in providing services to particular sub-groups (chronically homeless persons with mental illness and/or substance abuse, youth, large families and/or families with teenage sons, and ex-offenders) was consistently reported by survey participant (U.S. Department of Housing and Urban Development [HUD], 2002).

In each of these reports, the difficulties of administrative and bureaucratic procedures, lack of reliable or adequate funding sources, and difficulty of serving the large numbers and special needs of the homeless client are common themes. Despite these seemly negative aspects, additional information asserts the McKinney-Vento Act does provide quality of life and, arguably, life saving programs to large numbers of homeless individuals and families. Advocates of the next generation of McKinney-Vento Act programs are lobbying for laws and programs that provide relief for, not only those who are currently homeless, but those individuals, youth and families that live in the shadow of this terrible social malady.

Interagency Council on the Homeless. The Interagency Council on the Homeless [ICH] was created under Title II of the 1987 Stewart B. McKinney Homeless Assistance Act. The ICH is acknowledged as the Working Group of the White House Domestic Policy Council (Interagency Council on the Homeless, Fact Sheet, 1995). The ICH is made up of sub-cabinet representatives from each of the 18 member agencies (see Title II, page 44-45).

The ICH provides leadership at the Federal level for the following major functions (Interagency Council on the Homeless, Fact Sheet, 1995, p. 1):

1) planning and coordination the Federal government's actions and programs to assist homeless people, and making recommending policy changes to improve such assistance;
2) monitoring and evaluating assistance to homeless persons provided by all levels of the government and the private sector;
3) ensuring that technical assistance is provided to help community and other organizations effectively assist homeless persons; and
4) dissemination information on Federal resources available to assist the homeless population.

Prior to 1996, the last national study conducted on homeless assistance providers and clients was conducted in 1987 by the Urban Institute. In 1996, the Interagency Council on the Homeless directed the U.S. Bureau of the Census to collect data (the Urban Institute analyzed the data collected) in order to determine the characteristics of the persons served, provide current information concerning the providers of service to this population, and comparison information to determine how the homeless population has changed since the 1987 national survey. The resulting survey report was printed in 1999 and is called the *National Survey of Homeless Assistance Providers and Clients (NSHAPC).* The *NSHAPC* surveyed 28 of the United States largest metropolitan statistical areas (MSA's), 24 randomly sampled small and medium MSA's, and 24 randomly sampled groups of rural counties (Interagency Council on the Homeless, 1999). The techniques used to collect data are as follows: 1) telephone interviews with 6,400 representatives of approximately 12,000 programs were conducted, 2) mail surveys were sent to 6,500 programs identified by the telephone interview, and 3) 4,200 consumers were interview in person (Interagency Council on the Homeless, 1999). This report is the most current national survey on the characteristics of the homeless and the providers that serve them. As such, the *NSHAPC* report is used extensively (in addition to other references) in this study to describe the characteristics of the homeless in the areas of: a) specific subgroups, b) ethnicity/race, c) patterns of homelessness, d) reasons for leaving home, e) economic characteristics, f) physical health, g) mental health and substance abuse, h) incarceration, and, i) education level of the homeless.

The *NSHAPC* was not designed to count the homeless, instead the survey set out to provide information about the characteristics of the homeless using homeless assistance programs, consumers, and the providers serving them. The *NSHAPC* (Interagency Council on the Homeless, 1999) looked at 16 types of homeless assistance programs including

> emergency shelters, transitional housing, permanent housing for the formerly homeless, programs offering vouchers for temporary housing, programs accepting voucher for temporary

> housing, food pantries (in rural areas), soup kitchens/meal distribution programs, mobile food programs, physical health care programs, outreach programs, drop-in centers, migrant housing used for homeless people, and other programs. (p. 1)

The final important aspect of the *NSHAPC* report is its comparison to the 1987 Urban Institute study. In comparing shelter and soup kitchen consumers, the *NSHAPC* (Interagency Council on the Homeless,1999) found that the ethnic/race status changed from less likely to be white (39 versus 46 percent) to more likely to be black (46 versus 41 percent). The *NSHAPC* (Interagency Council on the Homeless, 1999) also found that the homeless are better educated (completed high school), receive more government benefits, and report being less hungry than their 1987 counterparts. Perhaps one of the most significant findings of the *NSHAPC* (Interagency Council on the Homeless, 1999) is that no differences were found in the frequency of self reports of the homeless that had inpatient treatment for substance abuse or alcohol, or mental health issues, as compared to their counterparts in the 1987 study. This finding suggests that the issues of treatment for the homeless person suffering with chronic mental illness has not changed in the last 15 years despite reforms and significant breakthroughs in medication.

Homelessness and Persons with Chronic Mental Illness

Although ‘homeless’ is a single word, the collection of descriptive words necessary to develop the construct of ‘homeless’ could fill a room. At the turn of the twentieth century, homeless persons were looked down upon and considered an offensive site (Scientific America Magazine, 1901):

> One of the greatest problems that the large cities are called upon to solve is the housing of the poor. In London and New York in

> particular, attention is now given to the problem, due not only to the general spirit of altruism, but also to a realization that the old methods of housing the poor directly contributed to the spread of vice and pestilence. (p. 1)

During the years prior to the Great Depression, the community, churches and extended family units initially directly absorbed homeless persons and families. The events of that decade forced the emergence of U.S. federal welfare programs and sporadic state relief programs (Crouse, 1986). The homeless transient (primarily men) of the Great Depression experienced one of the first federal relief programs under the Federal Transient Program from 1933-1935 (Crouse, 1986). The next set of programs called 'The New Deal' programs and laws (enacted by a special session of Congress called by President Franklin Delano Roosevelt) were designed to stimulate the economy and protect the common worker in America (Current Events, 2001) 'The New Deal' social reform programs were the first of their kind. Among those programs and laws that would most impact the homeless and those in danger of becoming homeless, the Social Security Act, Workers' Compensation, Federal Emergency Relief Administration, Aid to Families with Dependent Children, Food Stamps, Works Progress Administration, and the American with Disabilities Act provided federal relief to approximately one third of the Americans President Roosevelt believed needed assistance (Current Events, 2001; Lowitt, 2001).

The 1970s and 1980s experienced a politically conservative shift from government responsibility for welfare to individual responsibility along with a sweeping dismantling of social programs that left marginalized persons (primarily the poor and deinstitutionalized persons suffering from mental illness) almost completely disenfranchised with little or no resources (Stern, 1984).

Currently, the social attitude concerning homelessness in the new millennium has benefited from the past 30 years of research conducted both publicly and privately. Rather than being seen as personal choice or individual defects, homelessness is seen as a socially constructed failure that occurs when families and individuals experience one or more catastrophic insults from which they lack the resources or social support to recover. The list of catastrophic insults is lengthy; however, research has illuminated several consistent themes: severe poverty; lack of affordable housing; chronic and/or severe physical illness; chronic and/or severe mental illness; chemical abuse/addiction; poor or inadequate education; developmental disabilities; abuse; neglect; domestic violence; exposure to combat; and lack of upward mobility in the work force (Goldman & Morrissey, 1985; Homelessness in the US, retrieved October, 2002; Interagency Council on the Homeless, 1999; Phillips, DeChillo, Kronenfeld & Middleton-Jeter, 1988; Proscio, 2000; USA Today Magazine, 1994; U.S. Department of Housing and Urban Development [HUD], 1995)

Counting the Homeless

Obtaining an accurate count of homeless persons is a difficult task. There are those persons who are homeless briefly, homeless for short periods of time repeatedly, chronically homeless for longer periods of time, homeless but ‘double up’ with relatives, and the ‘hidden homeless’ that sleep in cars, makeshift housing or abandoned buildings (Culhane, Dehowski, Ibanes, Nedham & Macchia, 1994; Link, Phelan, Bresnahan, Sueve, Moore & Susser, 1995; NCH Fact Sheet #2, retrieved October, 2002). There are several methods used to count the homeless: point-in-time (count all the homeless on any given day), and period prevalence (count the homeless over a given period of time) (NCH Fact Sheet #2, retrieved October, 2002). To date, there are four widely used sources which estimate the point-in-time incidence of the homeless: 1) HUD's 1984 count (U. S. Department of Housing and Urban Development, 2002); 2) The Urban Institute's 1987 survey (Burt & Cohen, 1989); 3) The 1990 Census Bureau Shelter count (Culhane et al., 1994; NCH Fact Sheet #2, retrieved October 2002) and 4) The National Survey of Homeless Assistance Providers and Clients (Burt, Aron & Lee, 2001; Interagency Council on the Homeless [ICH], 1999). In addition to these studies, Link et al. (1994) and (1995) published two studies that produced life-time and five year prevalence estimates of the homeless while Culhane et al. (1994) studied shelter turnover rates to estimate period prevalence counts. The Clinton Administration took the data from the Link et al. (1994) study to extrapolate an estimate (including children) of 4.95 to 9.32 million (approximately 7 million) homeless persons from 1985-1990 (U. S. Department of Housing and Urban Development, 1994). While these studies attempt to estimate the number of homeless using various techniques, the figures range from 2.5 to 3.5 million persons (children included) who are homeless at least one night in any given year (Interagency Council on the Homeless, 1999). Specifically in Georgia's largest city, The Atlanta Task Force for the Homeless estimations of the size of the metropolitan Atlanta homeless population in 1995 are as follows (Research Atlanta, Inc., retrieved October 2002): 1) a point-in-time estimate of homeless adults was established at approximately 11,300 for individuals for an average night in metro Atlanta for the year 1995; 2) a period prevalence estimate of homeless adults was established at 40,000 individuals for metro Atlanta in the year 1994 (an adjusted was made for error and over-counting). The most recent report submitted by the United Way of Metropolitan Atlanta, (contracted to Deloitte Consulting) "Blueprint to End Homelessness in Atlanta", reports an estimate of 12,000 unduplicated homeless persons in Atlanta, Georgia during 2001 (Research Atlanta, Inc., Retrieved October, 2002). Despite the logistical and political issues surrounding accounting for the number of persons that suffer from homelessness, this apprehensible condition occurs throughout the nation and world far too many times.

Subgroups of Homeless People

Although the homeless may share similar problems and issues, they should not be considered a homogeneous group needing similar services. Among the total homeless population are several subgroups that represent significantly different collections of individuals with special needs. The Interagency Council on the Homeless *National Survey of Homeless Assistance Providers and Clients* [ICH *NSHAPC*] 1999, surveyed 2,938 homeless persons face-to-face and compiled the following data concerning characteristics. This survey (ICH, *NSHAPC,* 1999) found that single men are the largest group, comprising 68% of all homeless surveyed. The next largest subgroup is comprised of veterans. They make up 23% of all homeless persons with 98% of this group being male (ICH, *NSHAPC,* 1999). Homeless families are the third largest group of homeless consumers. They represent 15% of the homeless population with 84% of this group headed by a female (ICH, *NSHAPC,* 1999). Homeless families have, on average, two young children. The gender of these children is about evenly divided between male and female. Homeless children are very young; 62% are from 0 to 8 years old (ICH, *NSHAPC,* 1999). Finally, there is a growing population of homeless youth (17-24 years old) that makes up 12% of the homeless population (ICH, *NSHAPC,* 1999). These ‘throw away’ youth are generally run away’s or foster care children. This sub-group is the least likely of all the sub-groups to receive standard services or referrals to specialized services (Aron & Sharkey, 2002). The vast majority of homeless clients are in the prime of life--81%--are between the ages of 25-54 years old (ICH, *NSHAPC,* 1999). The fact remains that, even though all these individuals suffer from homelessness, they are homeless for different reasons, and require diverse services for varying lengths of time.

Ethnicity/Race

The ICH *NSHAPC* (1999) compared its ethnicity/race data of currently homeless persons (n = 2938) to the data compiled by the Bureau of Census in 1997 and found that adult black non-Hispanics and Native Americans were inversely and disproportionately represented among the homeless as compared to the U.S. population. Specific to this study, 41% of adult homeless are white (non-Hispanic) as compared to 76% of the U.S. population (ICH, *NSHAPC,* 1999). In the minority groups of this study, 40% of adult homeless are black (non-Hispanic) as compared to 11% of the U.S. population (ICH, *NSHAPC,* 1999). In the next largest minority population studied 11% of adult homeless are Hispanic as compared to 9% of the U.S. population (ICH, *NSHAPC,* 1999). The greatest disparity is found within the Native American population. The ICH *NSHAPC* (1999) reports 8% of the homeless surveyed are Native American as compared to 1% of the U.S. population. Interesting enough, there is no percentage of Asians listed in the homeless. This race category is listed but was not self-reported as a race category among the homeless surveyed. The last category of 'Other' is listed as 1% of adult homeless population as compared to 3% of the U.S. population.

History of Homelessness, Transient vs. Chronic

Although the causes and contributors to homelessness are complex, there seem to be basically two different patterns of homelessness. The first pattern reported is one of episodic or transient homelessness frequency associated with a crisis in family structures (divorce, separation, or domestic violence) or economic instability (quitting or loosing a job)(Canton & Shrout, 1995; Cummings & Toomey, 1998; North & Smith, 1993). More often women with young children are found in this group (ICH, *NSHAP*, 1999). The second pattern of homelessness is longer in duration and chronic in nature. Significantly more often men than women, with critical and substantial histories in the areas of legal problems, substance abuse/addiction and serious mental illnesses are found in this group of long term consumers (Canton & Shrout, 1995; Cummings & Toomey, 1998; North & Smith, 1993). One major reason sited in the research as contributing to this phenomenon of chronic homelessness in the male population is the lack of access to welfare (North & Smith, 1993). Homeless men generally are single and do not qualify for the welfare benefits generally made available to other homeless populations.

In support of this pattern of homelessness, a prevalence study by Link et al. (1994) tracked and reports a similar history on the duration of homelessness. Of 1,507 persons surveyed nationally by telephone, 8% reported being homeless less than a week; 33% were homeless more than a week, but less than one month; 46% were homeless more that a month, but less than one year; and, 13% were homeless more than one year (Link et al., 1994). This study (Link et al., 1994) also found the incidence of lifetime homelessness (including brief periods of homelessness or doubling up with others) of any type is 14%.

In addition, the ICH *NSHAPC* (1999) reports on the frequency of homelessness that also supports the pattern of transient vs. chronic homelessness. Of the 2,473 single homeless persons interviewed face to face (availability sample), 49% of this group report being homeless once while 37% have been homeless more than two times (ICH, *NSHAPC,* 1999). Of the 465 consumers in homeless families, 50% of families report being homeless once while the other 50% have been homeless more that two times (ICH, *NSHAPC,* 1999). In addition, 34% of single persons report being homeless 25 months or more; 49% of families report being homeless 3 months or less (ICH, *NSHAPC,* 1999).

Reasons for Leaving Home

Multiple reasons for leaving home were provided by the 2,938 consumers interviewed; however, there were six common reasons shared by at least five percent of this population (ICH *NSHAPC* 1999). Those reasons cover not being able to pay the rent, losing a job, eviction, not getting along with others, abuse in the household, and doing drugs (ICH, *NSHAPC,* 1999). Specifically, 38% of families report leaving home because they could not pay the rent, their job ended, or the landlord evicted them (ICH, *NSHAPC,* 1999). In addition, 13% of families report leaving home due to child abuse and/or domestic violence (ICH, *NSHAPC,* 1999). Within the single homeless population, 35% report leaving home because they could not pay the rent, became unemployed, or the landlord evicted them (ICH, *NSHAPC,* 1999). Within the single homeless population, only 2% site domestic violence as a reason for leaving home (ICH, *NSHAPC,* 1999). In the area of not getting along with others, 3% of families and 5% of single homeless consumers reported this as the reason for leaving home (ICH, *NSHAPC,* 1999). Finally, 4% of families and 7% of single homeless consumers reported doing drugs as the reason for leaving home (ICH, *NSHAPC,* 1999).

Economic Characteristics

In keeping with the reasons for leaving home, the most consistent characteristic of all homeless persons regardless of race, gender, or status (single or family) is their lack of income and pervasive poverty. The single homeless client has an income that is 51% below the federal poverty level of $680 a month while the homeless family is 46% below the federal poverty level of $1,023 a month (ICH, *NSHAPC,* 1999). The average monthly income for a homeless family is

$475 while the average monthly income for a single homeless person is $348 (ICH, *NSHAPC,* 1999). This level of severe poverty is not eased despite the report that 79% of homeless families receive some form of government benefit (AFDC 52%, Food stamps 71%, Medicaid 61%, SSI 11%) and 39% of single homeless persons receive some form of government benefit (SSI 11%, Food stamps 31%, Medicaid 25%)(ICH, *NSHAPC,* 1999). In addition to the lack of housing, 40% of the homeless say they did not eat for one day--due to lack of resources (Food and Consumer Service, 1999). During the past 30 days, 39% say they were hungry and did not have enough food to eat during this period of time -- also due to lack of resources (Food and Consumer Service, 1999). Homelessness is not just the misfortune of not having a home; it is a combination of catastrophic insults that culminates in the ultimate injury of losing stable shelter.

Physical Health

Compounding the multiple catastrophic problems faced by the homeless is the added severity of health issues resulting from lack of care, poor nutrition, minimum educational levels and risky lifestyles. According to Link et al. (1994), “The conditions of homelessness pose severe problems for the control of infectious diseases such as tuberculosis and the acquired immunodeficiency syndrome and put homeless people at risk of serious adverse physical and mental health effects”(p. 1907). The ICH *NSHAPC* (1999) reports that 55% of the homeless are without medical insurance coverage (n = 2938). The lack of medical insurance for all Americans living in houses is reported in this study at 16%. The chronic health conditions (arthritis, high blood pressure, diabetes or cancer) of the homeless are self-reported at 46%; in addition, 26% report infectious conditions (cough, cold, bronchitis, pneumonia, tuberculosis, sexually transmitted diseases other than AIDS); the homeless report that 8% have skin ulcers, lice or scabies; 3% of the homeless indicate they have tuberculosis; and, 3% report they have AIDS (ICH, *NSHAPC,* 1999).

Two additional studies also report a higher than normal population rate of HIV infection, tuberculosis, substance abuse and alcohol abuse among the homeless as compared to their housed counterparts (Goldfinger, Susser, Roche & Berkman, 1998; Saez, Valencia, Conover & Susser, 1996). These health, mental health, and substance abuse problems play a significant role in the cause of death for the homeless. In a study conducted in Atlanta, Georgia, Dr. R. Hanzlick, and Dr. R. Parrish (1993), compiled information on the causes of death of the homeless from 1988-1990. They found that among the 128 deceased persons identified as homeless, 125 were men, 77 were black, and the average age of the deceased was 46 years old (Hanzlick & Parrish, 1993). The death certificates for 55% of this group listed the cause of death as natural, 8% were murdered, 3% committed suicide, and 31% were determined to be unintentional fatal injuries (Hanzlick et al., 1993). Most of the deaths (55%) occurred outdoors, with 80% found dead on site (Hanzlick et al., 1993). Of all the deaths recorded, only three deaths occurred in a shelter (Hanzlick et al., 1993). The study also reports that 62% of all deaths were related to either chronic or acute effects of alcohol (Hanzlick et al., 1993). These individuals died young, often without shelter, and a significant percentage were under the influence of alcohol.

Mental Health and Substance Abuse

The debate concerning how many homeless persons are mentally ill and/or suffer from substance abuse runs juxtaposed to the debate on how to alleviate the problems of their homelessness. It has been previously reported that there are quite different subgroups within the homeless population. Although each subgroup presents with unique needs and may require different services for mainstream reintegration, each subgroup is over represented with persons suffering from mental illness and/or substance abuse (Cohen & Thompson, 1992; Interagency Council on the Homeless, 1999; Treatment Advocacy Center, retrieved October, 2002). It is estimated that 200,000 persons suffering from schizophrenia and manic-depressive disorder live in the streets (Treatment Advocacy Center, retrieved October, 2002F). This estimate, of course, does not include the other various mental illnesses such as PTSD, anxiety disorders, results of abuse and neglect, and substance abuse.

The presence of mental illness and substance abuse in the homeless population is not a new problem. In 1918, a New York psychiatrist by the name of Amos Baker examined 50 'vagrant' inmates of the Westchester County Penitentiary and found 76% exhibiting psychiatric pathology (Goldfinger, 1990). The Department of Housing and Urban Development conducted a survey in 1984 and reported that 22% of the homeless in shelters suffered from mental illness (Department of Housing and Urban Development, 1984). That same year, The American Psychiatric Association [APA] reported the incidence of serious and chronic mental illness among the homeless was between 25% and 50% (Arce & Vergare, 1984, pp. 75-90). According to Cohen and Thompson (1992) "more scientifically rigorous studies sponsored by NIMH have found between one-fourth and one-third of homeless persons to be severely mentally ill. Despite the earlier methodological flaws, it is evident that a disproportionate number of homeless persons have severe mental illness" (p. 817). The ICH *NSHAPC* (1999) further validates the issue of a long-term problem of chronic mental illness among the homeless in its finding that there was no differences in the self-report of drug, alcohol and mental health problems as compared to the 1987 Urban Institute national study.

Deinstitutionalization from state hospitals beginning in the1950s and lasting through 1980s of those persons suffering from chronic mental illness proved to produce a tremendous strain on the communities originally thought able to support them (U.S. Department of Health and Human Services, 1999; Wolff and Stuber, 2002). Goldman and Morrissey (1985) report that "between 1950 and 1980, for example, the resident population of state mental hospitals was reduced from approximately 560,000 to less than 140,000 . . ." (pg. 278). The lack of community support placed those persons being discharged from mental institutions at great risk of relapse (Cohen & Thompson, 1992). Lack of skills and resources to provide for themselves in the areas of basic needs, let alone in the areas of mental health and substance abuse, eliminated options and forced many of this group to resort to living on the streets (Cohen & Thompson, 1992; Interagency council on the Homeless, 1999). Further exacerbating the stabilization of the homeless person with mental illness is the lack of follow-up care or place to live upon discharge from a state institution (Cohen & Thompson, 1992). The sentinel report *Outcasts on Main Street: Homelessness and the Mentally Ill* (National Institute of Mental Health, 1992) provides this shocking view of life for those homeless persons suffering from various forms of mental illness:

> Most severely mentally ill people who are homeless find it difficult, if not impossible, to improve their lives appreciably on their own. Disorientation, mistrust, fear of re-hospitalization, ignorance, lack of motivation, language problems, and poverty keep them from enlisting the aid of others and maintaining contact with many of the resources that significantly might enhance their well being. (p. 26)

People with serious mental illnesses and co-occurring substance abuse disorders who also are homeless experience great difficulties in all aspects of their lives. People with both of these disorders are at greater risk for homelessness as they tend to have more severe symptoms of their mental illnesses, deny both their mental illnesses, and their substance abuse problems, refuse treatment (including medications), and abuse multiple substances (Burt, Aron & Douglas, 1999; Fischer & Breakey, 1991; Gonzales & Rosenheck, 2002). They may be antisocial, aggressive, and, when not receiving treatment, sometimes may be violent (Burt et al., 1999; Fischer & Breakey, 1991; Gonzales & Rosenheck, 2002).They also have higher than average rates of suicidal behavior and ideation (Burt et al., 1999; Fischer & Breakey, 1991). Individuals with co-occurring disorders who are homeless often have more severe health problems, poorer community adjustment, and poorer one-year outcomes compared to other homeless individuals with serious mental illnesses alone (Gonzales & Rosenheck, 2002).

Once homeless, people with co-occurring disorders require extensive assistance to reach and receive services they need, are more likely to remain homeless, and stay homeless longer than other subgroups (Winarski, 1998). They are more likely to be older, male and unemployed; to be homeless longer and living in harsher conditions; and to suffer greater distress, demoralization, and alienation from their families. They tend to be isolated, mistrustful, and resistant to help (Dixon & Osher, 1995).

The ICH *NSHAPC* (1999) further supports these findings and reports the lifetime incidences of any alcohol, drug, and mental health problem [ADM] among the 2938 homeless individual interviewed as follows: 1) 86% of the homeless report a lifetime problem of any ADM; 2) 62% report a lifetime problem that is alcohol related; 3) 58% report a lifetime problem that is drug related; and, 4) 57% report a lifetime problem that is mental health related. As earlier stated, these percentages have not changed since the 1987 Urban Institute national study (ICH, *NSHAPC,* 1999). The issues of alcohol, drug, and mental health problems, and the co-occurring difficulty of the homeless/near homeless to obtain consistent and reliable treatment, remains the driving force of the Grady Health System to operate the COS. The following diagram depicts the intertwining of the self-reported problems in the areas of mental health, drugs, and alcohol among the homeless.

Incarceration

In addition to the above reported problems and behaviors, the incarceration rate for the homeless is higher than the national average (Interagency Council on the Homeless, 1999; Treatment Advocacy Center, retrieved October 2002). When all incarceration experiences are taken into consideration, the homeless report a 54% rate, the former homeless report a 45% rate (n = 2938), and the non-homeless population that was interviewed (n = 518) reported a 14% rate of any incarceration (ICH, *NSHAPC,* 1999). The homeless are often arrested for incidents they have little choice over – loitering, looking for food, or behaviors associated with the diseases of mental illness and substance abuse (ICH, *NSHAPC,* 1999). Homeless mentally ill consumers are often incarcerated with no coordination of mental health care, poor discharge planning and cessation of welfare benefits that contribute to failure to thrive once the jail term is served (Cohen & Thompson, 1992; The Bazelon Center for Mental Health Law, 2001; Treatment Advocacy Center, retrieved October 2002). There are an estimated 300,000 individuals (16% of the inmate population) with schizophrenia or manic-depressive illness in jail or prison (Treatment Advocacy Center, retrieved October 2002). In many instances, the use of public institutions (emergency rooms, hospitals, mental health crisis units and jails) are indicated by homeless consumers as attempts to find shelter, food and care (Treatment Advocacy Center, retrieved October 2002; Proscio, 2000). The Bazelon Center for Mental Health Law (2001) further adds,

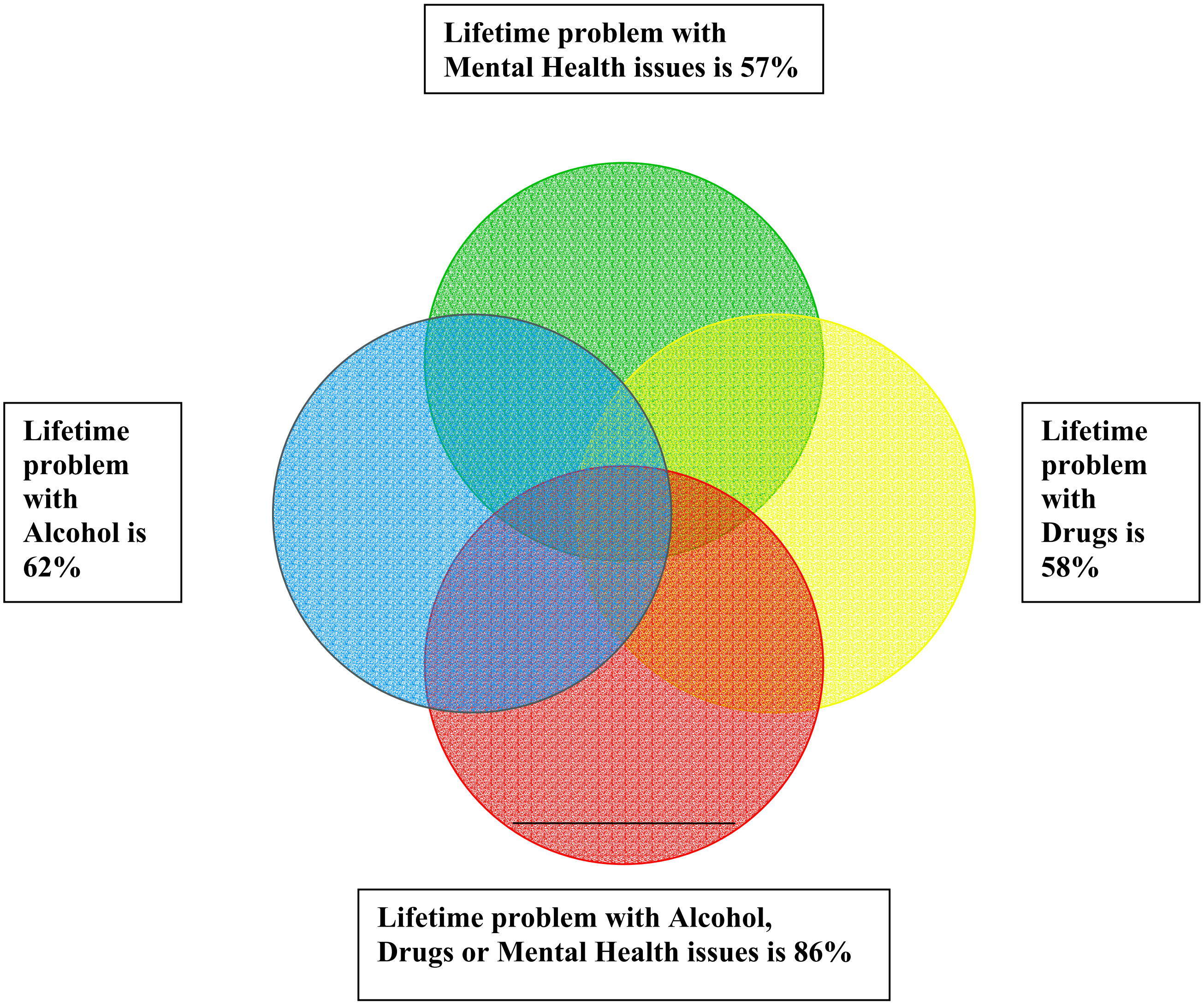

Figure 2. Alcohol, Drug, and Mental Health Problems Among the Homeless

Yet, whether because relevant federal rules are not well understood or because state implementation of them is problematic, many people with severe mental illness unnecessarily lose their federal entitlements while in jail. The resulting poverty and lack of access

> to health care can lead to incidents that greatly increase the likelihood that these individuals will have further contact with law enforcement. Without income support or health coverage, many people with severe mental illness become caught in a cycle of recidivism. (p. 1)

The ICH *NSHAPC* (1999) provides the following self-reported incarceration rates for the 2938 homeless consumers interviewed: 1) 54% report a lifetime history of incarceration; 2)16% have been in juvenile detention; 3) 18% have spent time in a state or federal prison; and 4) 49% have spent five or more days in a county jail (ICH, *NSHAPC,* 1999).

Social workers, family members, physicians, and other advocates providing care to this population echo the Treatment Advocacy Center (2001) belief that “The woeful failure to provide appropriate treatment and ongoing follow-up care for patients discharged from hospitals has sent many individuals with the severest forms of brain disease spinning through an endless revolving door of hospital admission and readmissions, jails, and public shelters” (Treatment Advocacy Center, retrieved October 2002, p. 2). The belief that the homeless are just lacking permanent shelter is a horrible simplification of the issues surrounding homelessness. The lack of ability to sustain stable housing is a final visible result of the culmination of catastrophic insults rendering the individual incapable of any level of self-determination.

Education Levels of the Homeless

Lack of education, low levels of academic achievement, and few job skills are significant issues contributing to the vulnerability and inability of homeless persons to maintain a stable environment. Single homeless individuals (n = 2473) report a high school drop out rate of 38 percent while the adult U.S. population (ages 25 and older) report a 25 percent drop out rate

(ICH, *NSHAPC,* 1999). Within this same homeless population, 34 percent have a high school diploma while their counterparts within the U.S. population also have a 34 percent achievement rate (ICH, *NSHAPC,* 1999). The greatest disparity is reported in the area of education beyond high school. The single homeless population reports a 25 percent rate of beyond high school education while the U.S. population reports a 45 percent achievement rate (ICH, *NSHAPC,* 1999). Homeless families report even more despairing drop out rates. Consumers in homeless families do not complete their high school education 53 percent of the time, obtain a high school diploma or G.E.D. only 21 percent of the time, and obtain education after high school approximately 25 percent of the time (ICH, *NSHAPC,* 1999). The issues of lack of education, low academic achievement, and few job skills are certainly illuminated when the ability to make a living wage to sustain independence is a primary event in the cycle of homelessness.

Best Practices Model of Service Delivery to the Homeless

From 1993 to 1995, The Department of Housing and Urban Development [HUD] initiated, in several stages, a competitive based application program for McKinney-Vento funds called the Continuum of Care [CoC] approach. Prior to this initiative, there was no formal requirement or incentive to ascertain needs, organize planning, collaborate on service delivery, or indicate how funds would be used for the homeless (U. S. Department of Housing and Urban Development, 2002). The Urban Institute evaluated 25 CoCs selected in all major regions of the United States. A summary of its important findings and suggestions for developing a successful model of service delivery indicates that most successful homeless assistance programs act as a single system, providing all of the following services: prevention, outreach and assessment, emergency shelter, transitional housing, appropriate supportive services (mental health, substance abuse, domestic violence and job readiness), permanent supportive housing, and permanent housing (U. S. Department of Housing and Urban Development, 2002).There are several core key operating components for a ‘best practices’ model of successful service delivery to the homeless. The first step in the development of a ‘best practices’ model is the creation of a local interagency coordinating body with formal decision making authority to insure the development and implementation of a common mission (U. S. Department of Housing and Urban Development, 2002). The next step is to assign a centralized authority that has decision making capacities for the homeless assistance system (U. S. Department of Housing and Urban Development, 2002). This centralized authority would be responsible for development of goals, policy and procedures, and day to day operation of the collaborative. The centralized authority may also be the interagency coordinating body, thus serving a dual purpose and streamlining the information flow. Another essential key component in the ‘best practices’ model is maintaining and training staff with the responsibility to promote systems and service information sharing and integration (U. S. Department of Housing and Urban Development, 2002). It is paramount to the success of a ‘seamless’ system that all service delivery members know what services are available and how to expedite access for each consumer regardless of the door of entry. Logistically the adoption and use of an interagency management information system (MIS) would help facilitate information sharing and referrals (U. S. Department of Housing and Urban Development, 2002). A final key component to the ‘best practices’ model is the co-location of mainstream services within homeless-specific agencies and programs (U. S. Department of Housing and Urban Development, 2002). This issue may be very difficult to implement inasmuch as service delivery providers often evolve over time with the issue of co-location to another service delivery provider being an after thought. Location for a specific service delivery provider may perpetuate their particular mission but not necessarily the collaborative mission. The overall success of the ‘best practices’ model rest heavily upon the collective planning and willingness of the collaborative service delivery providers to share in the development of a common vision.

Although the HUD Continuum of Care program is still a relatively new development, the formal requirement of organizing all pertinent service providers within a community shows results in organizing service delivery and providing a solution to homelessness while maintaining the uniqueness of each community, allowing for flexibility in planning, and striving to preserve the integrity of the individual.

The Importance of Transitional Housing within the CoC program

In 1990, the National Institute of Mental Health and the Center for Mental Health Services sponsored a major research project at five sites designed to provide information concerning housing outcomes for homeless persons with mental illness who were provided additional supportive services. The result from these five projects (Shern, Felton, Hough, Lehmam, Goldfinger, & Valencia, 1997) . . .

> demonstrated that effective methods are available for combining housing and supportive services to successfully serve homeless persons with severe mental illness. Our challenge is to develop strategies to support these proven methods. (p. 241)

This salient piece of research, in addition to the *Stewart B. McKinney Homeless Programs PD&R Report* (Interagency Council on the Homeless, 1999) to Congress in January of 1995, proposed “an approach that will empower local communities with the flexibility to develop comprehensive, integrated homeless assistance strategies that are responsive to their needs and resources” (p. 1).

A study completed by Culhane, Metraus, and Hadley in 2001 further strengthens this model by reporting that "homeless people placed in supportive housing experience marked reductions in shelter use, hospitalization (regardless of type), length of stay per hospitalization, and time incarcerated" (p. 1). In addition to the tremendous improvement in individual quality of life, this system of service delivery produces a reduction in service use of shelters, hospitals, mental institutions and jails (Culhane, Metraus, & Hadley, 2001).

This 'best practices' model of service delivery that marries supportive housing and integrated supportive services has been further developed and introduced by the Corporation for Supportive Housing's Health, Housing and Integrated Services [HHISN] of the California San Francisco Bay area. Although the long-term results are still being gathered by the Goldman School of Public Policy at the University of California at Berkley, substantial positive interim data are presented in the article "Supportive Housing and Its Impact on the Public Health Crisis of Homelessness, 2000" (Proscio, 2000). The HHISN supportive housing network compiled data on 253 residents of two supportive housing and integrated supportive services programs (Proscio, 2000). These residents are in various stages of recovery and not necessarily 'clean and sober'. They are also in various stages of dealing with emotional problems and mental illness. All residents suffered with various lengths and times of being homeless. This study reported a 58% drop in emergency room use (255 visits) in the year following move-in compared to 535 emergency room visits the year prior to move-in (Proscio, 2000). In addition to this dramatic drop in emergency use, a 57% drop in medical inpatient days was also reported on a sub-group of 132 residents (Proscio, 2000). Finally, there was an elimination of residential mental-health treatment program days at the end of the one-year move-in date for a sub-group of 157 residents (Proscio, 2000). These results are directly attributed to the multi-agency planning and support, the integrated and flexible on-site supportive services, and the hard work of the residents. As one resident said after reviewing the report, “When I look at those charts, I see my life. That’s my story, and I know it’s right” (Proscio, 2000, p. 21).

The following figure is a visual representation designed by the researcher to represent a ‘Best Practices Service Delivery Model’ with the Interagency Planning Body, trained staff, and management information system at the heart of service delivery. All other programs surround and provide a strong working unit from which service delivery is coordinated for maximum benefit. This model was developed by the researcher using the literature on this subject to visually demonstrate what the research in this area seems to support.

Faith-based Service Delivery vs. Secular Service Delivery

In a separate study, Laudan Aron and Patrick Sharkey (2002) evaluated the ICH *NSHAPC* with the focus being a comparison of faith-based and secular non-profit programs for the homeless. Aron and Sharkey found that, of the 40,000 homeless assistance programs surveyed, faith-based non-profit organizations operate about one third, in addition to running the majority of all the food programs, and a quarter of the shelters and drop-in centers (Aron & Sharkey, 2002). At least half of the homeless assistance programs and 40% of all health programs are run by secular non-profit organizations (Aron & Sharkey, 2002). This study also reports that faith-based programs are less likely than secular programs to have a special focus such as mental health, substance abuse, or domestic violence (Aron & Sharkey, 2002). This particular finding is extremely important given the well established fact that there are several critical issues that the homeless have that require professional attention. Government funding is limited within the faith-based programs. Over half (62%) of the faith-based programs are self-funded and almost all (90%) obtain less than half of their operating monies from the government

(Aron & Sharkey, 2002). This greatly limits the ability of faith-based programs to provide more than food and shelter. Mental health and substance abuse issues contribute significantly to the

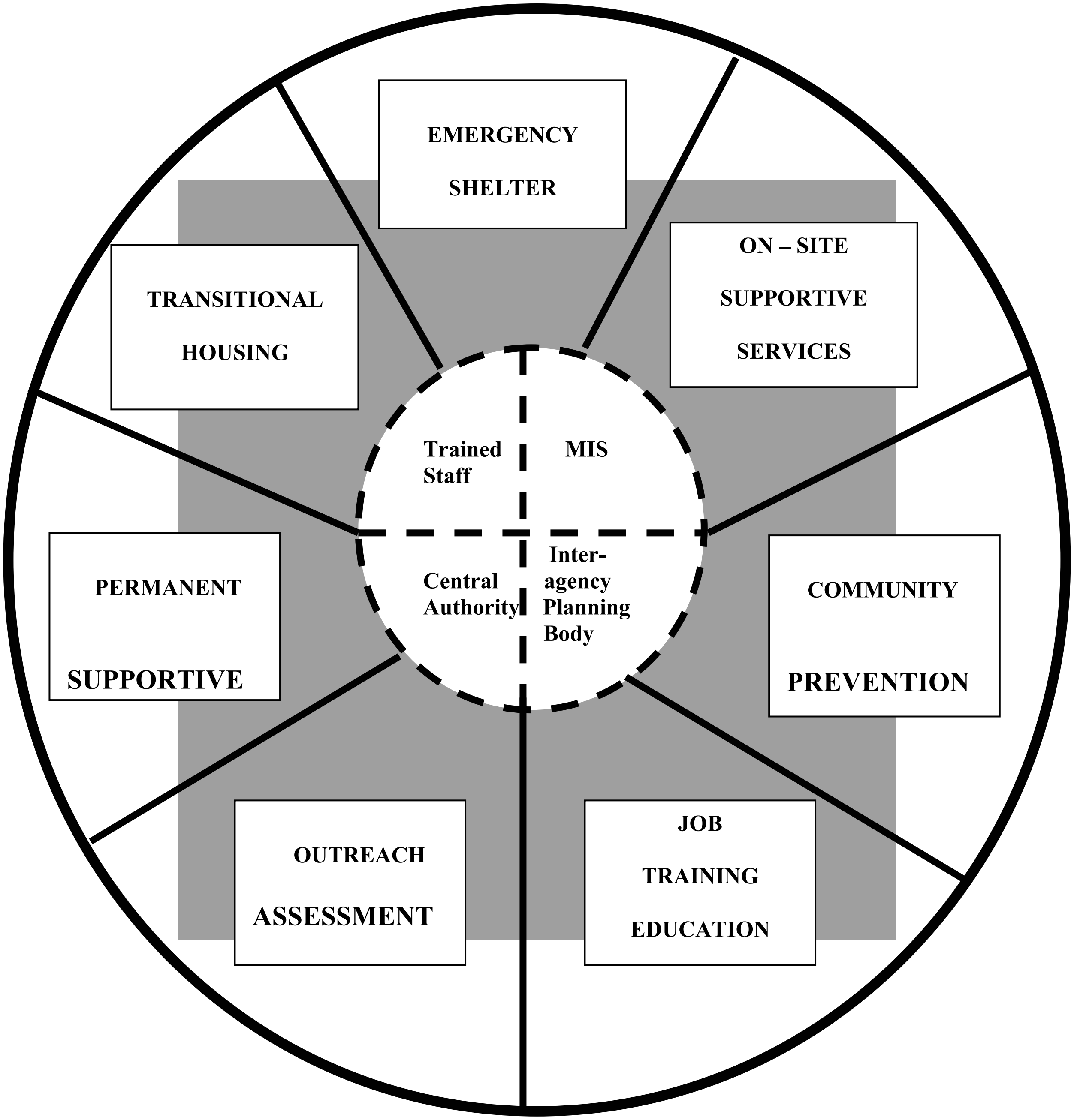

Figure 3. Best Practices Service Delivery Model

problems of stabilization and re-domiciliation (tenure in housing) of the chronic homeless population while poor job readiness and family instability (especially domestic violence) significantly contribute to the reasons for transient homelessness (Interagency Council on the Homeless, 1999; Lipton, Siegel, Hannigan, Samuels, & Baker, 2000; Proscio, 2000; Shern, Felton, Hough, Lehman, Goldfinger, & Valencia, 1997). Aron and Sharkey (p. 1, 2002) support this position, stating “Adequate and affordable housing, a living wage, and critical support services such as childcare and substance abuse treatment, are key to reducing homelessness.” In response to the faith-based funding issues, The Compassion Capital Fund, a new federal program created in 2002, will match private monies with federal dollars to help the faith-based programs develop critical social services programs and additional research to continue the development of best practices models of service delivery. Regardless of the type of organization or the funding sources, the cohesiveness of the agencies providing services, combined with a central authority and continuum of care planning, proves to provide an effective program model for service delivery to the homeless.

Problem areas within alternative or partial models

The HUD CoC evaluation also uncovered several consistent issues that presented problems in developing a successful model of service delivery for collaboratives (U. S. Department of Housing and Urban Development, 2002). The lack of formal leadership or interagency coordinating body was found to be the primary issue with CoCs that did not run effectively. Without formal leadership, services were often fragmented and the mainstream agencies were not able to coordinate support or leadership to other support services. This had the direct effect of increasing the cost of service delivery for each of the agencies involved in the CoC. Different services providers unable or unwilling to provide on site or near site services.

Service providers did not have a common vision or the leadership to provide this vision. In addition, strategic planning was tedious and often required more time than expected. The CoCs that did not run effectively also had in common a lack of power to enforce data gathering information to further support strategic planning. Part of this was due to a lack of compatibility of different data systems within the network of service providers. This lack of compatibility had the immediate result of service providers being unable or unwilling to share information concerning consumers requesting service.

Homeless people are not all the same. Homeless men seem to have longer, chronic periods of homelessness directly related to substantial mental health, substance abuse and legal issues. Homeless families (primarily headed by single women) have significantly shorter periods of homelessness that are directly related to lack of family support, economic instability or poor job skills. Finally, a growing population of foster care and runaway youth, often with serious emotional problems and significant juvenile legal histories are now living on the streets. Each of these subgroups represents significant challenges to the social welfare system. The provisions of critical professional social service programs (mental health, substance abuse, domestic violence, and job readiness) are paramount to the development of a best practices model of service delivery and establishment of tenure in housing for the homeless. In response to the conditions and difficulties faced by the consumers discharged during the 1970s from state institutions in the Atlanta Georgia area, the Grady Health System designed a community mental health service system set up to assist this particular population of disenfranchised persons. The Grady Health System COS is part of a Continuum of Care for the Atlanta Metropolitan area for providing service to the homeless/near homeless population. The next three chapters of this study will describe the design of the study, present and analyze the data collected, and provide recommendations and conclusions derived from the evaluation of data collected on the service delivery of the COS.

CHAPTER 3

METHODS

Description of Methods

"The term *research design* refers to all the decisions made about how a research study is to be conducted" (Rubin & Babbie, 1997, p. 341). As described earlier in Chapter 2, four stages of development were required prior to gathering data. In stage one, the Advisory Team (COS Medical Director,Dr. Rosalind Mance; COS Director Shelia Beckum-Head; appointed social workers; and staff) was interviewed and the determination was made that the objective-orientated approach (commonly referred to as the Tylerian Evaluation Approach) would be utilized (Fitzpatrick et al., 2004; Worthen et al., 1997). This process includes: a) establishing goals or objectives; b) classifying the goals or objectives; c) defining objectives in behavioral terms; d) finding situations (with the program) the objectives are used in; e) developing or selecting measuring techniques; f) collecting data; and g) comparing data with behaviorally stated objectives (Fitzpatrick et al., 2004; Worthen et al., 1997, p. 82). The objectives of this type of research need not be stated explicitly; rather, the objectives stated by the program goals will provide the foundation for the development of hypothesis (Fitzpatrick et al., 2004; Worthen, et al., 1997).

The second stage was comprised of open-ended interviews with the Advisory Team for the purpose of developing themes related to the goals and objectives of the COS. In the third stage, the researcher replaced the divergent interviewing process with a convergent process of developing specific questions. The Advisory Team was asked to prioritize the questions and select the questions for the focus of this study. In the fourth stage, four questions were selected that focused on quality of life for the COS consumer, achievement of COS goals (hospitalization rates, contact with consumers, contact with family and significant others, referral services, and services to the homeless), and discharge information. Those four questions were developed into two hypotheses and five statements that are the center of this study. During this stage, it was determined that the design of this confirmative, objectives-orientated study would be a cross-sectional, correlational, quantitative-descriptive, Sub-type B program evaluation (Tripodi, Fellin & Meyers, 1983). The purpose of a correlational study is two fold: 1) to determine whether there is a relationship between the paired sets of data in each hypothesis and, 2) to determine how statistically significant that relationship is, assuming that the relationship is not spurious (Schuyler & Cormier, 1996).

The methods employed to obtain data include: agency management information system (MIS) reviews, consumer record reviews, service delivery observations, staff interviews, administration of surveys, and consumer interviews. Permission to conduct the study was achieved by approval of the University of Georgia School of Social Work dissertation committee, University of Georgia Institutional Review Board, Emory University Institutional Review Board (the researcher was required to obtain research certification at Emory University), and the Grady Health Systems Research Committee.

Sources of Data

Data were collected from all available records of the population of solicited consenting adult consumers (see Appendix H for consent form) in the COS program during a specified 3-month period of time (see Table 2 for Data Collection Design, Grady Health System Community Outreach Services). A systematic sampling technique (Rubin & Babbie, 1997) was used in which all charts were alphabetized, numbered, and then selected charts were pulled using a random number table (Rosenthal & Rosnow, 1991). If the record met the specifications set by the hypotheses, the data were collected. Data were obtained from medical charts (n=40, and face to face interviews with a convenience sample, n=10). This number was established using Keppel's (1991, pg. 72) sample size chart of *Design and Analysis: A Researcher's Handbook*. The sample size (n=50) was determined to be ample (Cohen, 1988) with power set at .80, alpha =.05, and effect size = .06 (Keppel, 1991). The sample size will vary according to the question and design. Q1 will utilize an availability sample with an n = 50 of open cases of consumers that have utilized the COS for at least one year. Q2a will obtain n = 25 open cases of geriatric consumers that have utilized the COS for at least one year. Q2b and Q2c will split n = 100 equally between an availability sample of active cases and closed cases. Q2d sample size is 25 systematically selected open homeless client cases. Q3 sample size will use the same available active cases as Q1. Q4 sample size will be from the same closed cases as Q2b. The sampling ratio is established at 50/300, with N = 300 being the approximate population size of the COS consumers (Rubin & Babbie, 1997). The next section list each question and the methodology used to determine efficacy.

Operationalization of Variables and Use of Instruments

Q1. (Hypothesis One).The quality of life improvement of COS consumers will be assessed using the BASIS-32 (see Appendix G) on systematically selected charts. A comparison will be made using the admission form of the BASIS-32 and one year repeat of the BASIS-32.

Q2a. (Hypothesis Two).The hospitalization rate of the geriatric consumers will be obtained by doing a chart review of systematically selected active geriatric records and recording the results on a summary sheet (see Appendix C).

Q2b. (Descriptive Variable One). The Flexibility of Interventions (meeting places, milieu of treatment, meeting times, and availability of transportation) will be obtained by doing client interviews and systematically selected chart reviews active and closed cases and recording the results on a summary sheet (see Appendix B).

Q2c. (Descriptive Variable Two). Family and Significant other contacts will be obtained by doing a chart review of systematically selected active and closed cases and recording the results on a summary sheet (see Appendix A).

Q2d. (Descriptive Variable Three). Linkage to mental health services for the homeless consumers will be obtained by doing client interviews and a chart review of systematically selected active homeless records and recording the results (see Appendix D).

Q3. (Descriptive Variable Four). Information regarding the success of the COS referral process will be obtained by doing a chart review of systematically selected active records and recording the results (see Appendix E).

Q4. (Descriptive Variable Five). Information concerning discharge and case composition will be obtained in chart reviews of discharged clients and the results will be recorded (see Appendix F).

Data Collection and Other Procedures

The outline of the sequencing of data collection, process of collection, and the methods used to obtain the data is summarized in Table 3. Data Collection Design, Grady Health System Community Outreach Services. The lists of each question and the corresponding hypotheses or descriptive variable, information required to answer the question, the source of date, the method of collection the data, and the specific analytical procedure to determine efficacy is summarized in Table 4. Data Management Plan, Grady Health Systems Community Outreach Services.

Table 3.

Data Collection Design, Grady Health System Community Outreach Services

	March	April – June	July
1. Quality of Life improvement (n = 50)	O_1		
2. Family/SO contacts (n = 100)	O_2, O_3		O_4
3. Case Interventions (n = 100)	O_2, O_3		O_4
4. Geriatric Hospitalizations (n = 25)		O_2, O_3	
5. Mental Health access, Homeless (n = 50)		O_2	
6. Referral Information (n = 50)	O_2		O_4
7. Discharge Information (n = 50)	O_3		

O_1 = Agency MIS; O_2 = Active Files; O_3 = Closed Files; O_4 = face to face interviews

Table 4. Data Management Plan Grady Health System Community Outreach Services

Evaluation Question	Information Required	Data Source	Strategy/Method of Collecting Information	Analysis Procedure
Q1 H1	Quality of Life improvement	Basis-32, current Basis-32, 1 year n = 50	Review and tabulation	Correlational paired t-test
Q2a H2	Hospitalization Records, Geriatric	Active Files, n = 25	Review, tabulation	Correlational paired t-test
Q2b V1	Case Interventions	Active Files, n = 50 Closed Files, n = 50	Review, tabulation	Descriptive and Numeric
Q2c V2	Family/SO contacts	Active Files, n = 50 Closed Files, n = 50	Review and tabulation	Descriptive and Numeric
Q2d V3	Mental Health access, Homeless	Client records, n = 25	Review, tabulation interview	Descriptive and Numeric
Q3 V4	Referral Information	Active Files, n = 50	Review, tabulation interviews	Descriptive and Numeric
Q4 V5	Discharge Information	Closed Files, n = 50	Review and tabulation	Descriptive and Numeric

CHAPTER 4

PRESENTATION AND ANALYSIS OF DATA

This section of Chapter 4 contains the tabulated results of the program evaluation. Each evaluation question and corresponding hypothesis will be stated first. The questions are listed as Q1, Q2, Q3, and Q4. The hypotheses are listed next as H1 and H2 with the results listed in sequence as R1 and R2. The descriptive variables are listed as V1, V2, V3, V4, and V5 with a summary of the descriptive statistics. Next, tables displaying descriptive statistics and are used to report the results.

Q1. Does the quality of life improve for COS consumers?

H1. Consumers of the COS will demonstrate a statistically significant improvement (two- tailed, paired t-test, alpha = .05, n = 50) in daily functioning (as measured by the BASIS-32) over a 1 year period of time. See Table 5 for a summary of sub-scale means, standard deviations, paired *t*-tests, and Pearson's *r*.

R1. Results of the BASIS-32 are separated into 5 sub-categories as listed: A) Daily Living/Role Functioning Domain; B) Relation to Self/Others Domain; C) Depression and Anxiety Domain; D) Psychosis Domain; and, E) Impulsive/Addictive Behavior Domain.

A. Daily Living/Role Functioning Domain: A paired-samples t-test was conducted to evaluate whether there was a statistically significant improvement in self-reported scores on the Daily Living/Role Functioning Domain of the BASIS-32 over a 1 year period of time. The results indicate that the mean score for the current test (M = 4.48, SD = 6.83) was significantly smaller (reject the null hypothesis) than the mean for the 1 year prior test (M = 6.16, SD = 7.91), t (49) = -2.702, p ≈ .00, Pearson *r* = .832. There is an inferred statistically significant self-report of improvement in the domain of Daily Living/Role Functioning.

B. Relation to Self/Others Domain: A paired-samples t-test was conducted to evaluate whether there was a statistically significant improvement in self-reported scores on the Relation to Self/Others Domain of the BASIS-32 over a 1 year period of time. The results indicate that the mean score for the current test (M = 4.72, SD = 6.12) was not significantly smaller (failed to reject the null hypothesis) than the mean for the 1 year prior test (M = 6.12, SD = 7.56), t(49) = -1.920, p ≈ .06, Pearson *r* = .735. There was not an inferred statistically significant self-report of improvement in the domain of Relations to Self/Others.

C. Depression and Anxiety Domain: A paired-samples t-test was conducted to evaluate whether there was a statistically significant improvement in self-reported scores on the Depression and Anxiety Domain of the BASIS-32 over a 1 year period of time. The results indicate that the mean score for the current test (M = 4.26, SD = 5.03) was not significantly smaller (fail to reject the null hypothesis) than the mean for the 1 year prior test (M = 5.04, SD = 6.13), t(49) = -1.709, p ≈ .09, Pearson *r* = .851.. There was not an inferred statistically significant self-report of improvement in the domain of Depression and Anxiety.

D. Psychosis Domain: A paired-samples t-test was conducted to evaluate whether there was a statistically significant improvement (reject the null) in self-reported scores on the Psychosis Domain of the BASIS-32 over a 1 year period of time. The results indicate that the mean score for the current test (M = 2.18, SD = 2.75) was significantly smaller (rejection of the null hypothesis) than the mean for the 1 year prior test (M = 2.84, SD = 4.11), t(49) = -2.045, p ≈ .046, Pearson *r* = .851. There was an inferred statistically significant self-report of improvement in the domain of Psychosis. Some research shows that this subscale is reported to have poor internal consistency as compared to clinical interview (Klinkenberg, Cho & Vieweg, 1998); therefore, this result may be tenable (Schuyler & Cormier, Chapter 9, 1996). In other words, the decision to reject the null hypothesis may in this case have the potential to result in a Type One error.

E. Impulsive/Addictive Behavior Domain: A paired-samples t-test was conducted to evaluate whether there was a statistically significant improvement in self-reported scores on the Impulsive/Addictive Behavior Domain of the BASIS-32 over a 1 year period of time. The results indicate that the mean score for the current test (M = 2.26, SD = 3.24) was not significantly smaller (failed to reject the null hypothesis) than the mean for the 1 year prior test (M = 3.04, SD = 4.06), t(49) = -1.776, p ≈ .08, Pearson *r* = .659. There was not an inferred statistically significant self-report of improvement in the domain of Impulsive/Addictive Behavior.

Q2. What is the frequency of success or effectiveness that is achieved concerning the stated goals of COS programs in these specific area:

A. Reduction of hospitalization in elderly population

H2. The elderly consumer of the COS will demonstrate a statistically significant decrease (two-tailed, paired t-test, alpha = .05, n = 25) in hospitalization rate in the one year period of time since admission to the COS as compared to the hospitalization rate 1 year prior to COS treatment.

R2. A paired-samples t-test was conducted to evaluate whether there was a statistically significant improvement in the hospitalization rate of the elderly COS clients 1 year post admission as compared to 1 year prior to admission in the COS. The average age was reported as M = 61 years, 1 month; SD = 7.25, range for age was 51 – 86 years, n = 18, missing = 7. The results indicate that the mean score for the post COS admission hospitalization rate (M = .68, SD = 1.03) was not statistically significantly smaller (failed to reject the null hypothesis) than the mean for the hospitalization rate prior to the COS program admission (M = .76, SD = .97), t(24) = -.310, p ≈ .76, Pearson *r* = .416.

B. Flexibility of Interventions (milieu of treatment, meeting places and, forms of contact) within a 5-month interval (December, 2001 to April 2002).

V1. The data collected for this service delivery question was benchmark and is aggregated and set up in frequencies (active files, n = 25; closed files, n = 25). Data gathered indicate that 66.0% of consumers surveyed see the psychiatrist less than 1 time per month; 26.0% of consumers surveyed did not see the psychiatrist once during the five month evaluation period; 66.0% of consumers surveyed see a therapist less than 1 time per month; and, 24.0% of consumers surveyed did not see a therapist once during the 5-month evaluation period. Data also indicate 100.0% of charts reviewed that have a physician's ordered for a monthly deacoanate shot do not receive a regular monthly shot. Data gathered on Community Visits indicate that 40.0% of consumers are visited in the community with 75.0% of this group seen less than once a month. Finally, 54.0% of consumers are contacted by telephone with 74.0% of this group receiving less than 1 telephone contact per month. See Table 6 for frequencies and percentages of physician psychiatric care, therapy visits, shots, community visits, and telephone contacts gatherer over a 5-month period.

C. Family and Significant Other contacts within a 5-month interval (December, 2001 to April 2002).

V2. The data collected for this service delivery question was benchmark, aggregated, and set up in frequencies (active files, n = 25; closed files, n = 25). Data gathered show staff recommending family/significant other contact 24.0% of the time while no contact by staff is recommended 50.0% of the time. See Table 6 for frequencies and percentages of: who recommended family contact, the form of the contact, and the type of contact the consumer has with their family/significant others.

D. Linkage to COS/HOPE Team services in Homeless population at first contact

V3. The data collected for this service delivery question was benchmark, aggregated, and set up in frequencies (active files, n = 25). Data collected in this area indicate that 36.0% of consumers are referred by Grady Health System followed by 32.0% referred by staff at shelters. Data indicate that 100.0% of consumers receive an assessment, 92.0% obtain referrals, 92.0% of consumers receive either a prescription or medication, and 56.0% receive therapy in addition to the assessment within the first contact period. Consumer return for follow-up appointments was documented at 100.0%. See Table 7 for a summary of services requested, services received, and return for follow-up services frequencies.

Q3. What is the status and rate at which COS consumers obtain referral services within a 5-month interval (December, 2001 to April 2002).

V4. The data collected for this service delivery question was benchmark, aggregated, and set up in frequencies (active files, n = 25). Data collected indicate staff helped the consumer make an appointment 48.0% of the time. Data also indicate that consumers accepted help 44.0% of the time. Outcome of referrals varied from 36.0% not indicated, 20.0% obtaining medical care, 8.0% obtained housing, and 4.0% check restarted. See Table 8 for information regarding referral services.

Q4. What is the case composition and reasons for COS program discharges?

V5. The data collected for this question was benchmark, aggregated, and set up in frequencies (closed files, n = 25). Grady Health System referred 48.0% of those consumers discharged while Georgia Regional Hospital referred 40.0%. Reason for discharge was due predominantly to refusal of services 48.0% of the time followed by program completion at a rate of 28.0%. See Table 10 for summaries of program discharges. In addition to this table, the following information was also collected: Length of Stay (LOS) (calculated in months), M = 46.8, SD = 50.5, range 1 month to 167 months; 17 males and 8 females were discharged; reported race composition (per Grady Health System standards) was 21 black and 4 white persons; employment status indicated n = 25 were unemployed; and insurance reportes indicate 11 persons received Medicaid, 3 persons received Medicare, and 11 persons

Table 5. Summary of BASIS-32 Sub-Scale Means, Standard Deviations, *t*-Tests, *p* Scores, and Pearson *r*

Sub-Scale	**Pre-Test Results**	**Post-Test Results**	**Paired *t*-Test and *p* Scores**	**Pearson's *r***
A. Daily Living/ Role Functioning	M = 6.16 SD = 7.91	M = 4.48 SD = 6.83	$t(49) = -2.702$ $p \approx .00$	$r = .832$
B. Relation to Self/ Others	M = 6.12 SD = 7.56	M = 4.72 SD = 6.12	$t(49) = -1.920$ $p \approx .06$	$r = .735$
C. Depression and Anxiety	M = 5.04 SD = 6.13	M = 4.26 SD = 5.03	$t(49) = -1.709$ $p \approx .09$	$r = .851$
D. Psychosis	M = 2.84 SD = 4.11	M = 2.18 SD = 2.75	$t(49) = -2.045$ $p \approx .046$	$r = .851$
E. Impulsive/ Addictive Behavior	M = 3.04 SD = 4.06	M = 2.26 SD = 3.24	$t(49) = -1.776$ $p \approx .08$	$r = .659$ M (r) = .786

were self-pay. Private insurance was not reported. Axis One diagnosis (APA, 2000) indicate 64.0% (n=16) were persons with various forms of Schizophrenia (295.xx) while 24.0% (n=6) were persons with various forms of Mood Disorders (296.xx). See Table 10 for summaries of Axis One diagnosis data.

Table 6. Frequencies of Interventions for a Five Month Interval (December 2001 to April 2002)

Intervention Per month	Physician		Therapy		Shots		Community Visits		Telephone Calls	
	Frequency	Percent	Frequency	Percent	Frequency	Percent (Valid)	Frequency	Percent (Valid)	Frequency	Percent (Valid)
.20	11	22.0	8	16.0	2	22.2	7	35.0	11	40.7
.40	14	28.0	11	22.0	2	22.2	5	25.0	4	14.8
.60	6	12.0	10	20.0	1	11.1	2	10.0	4	14.8
.80	2	4.0	4	8.0	4	44.4	1	5.0	1	3.7
1.00	3	6.0	2	4.0	---	---	3	15.0	1	3.7
1.20	---	---	2	4.0	---	---	1	5.0	4	14.8
1.40	1	2.0	1	2.0	---	---	---	---	1	3.7
1.80	---	---	---	---	---	---	---	---	1	3.7
3.00	---	---	---	---	---	---	1	5.0	---	---
Total	37	74.0	38	76.0	9	100.0	20	100.0	27	100.0
Missing	13	26.0	12	24.0	41	0.0	30	0.0	23	0.0

Table 7. Frequencies of Family and Significant Other Contacts during a Five Month Interval (December 2001 to April 2002)

Who Recommended Family and/or Significant Other Contact		
n = 50	Frequency	Percent
Staff	12	24.0
Consumer	5	10.0
Family/Significant Other	8	16.0
None	25	50.0
Form of Contact with Family and/or Significant Other		
n = 50	Frequency	Percent
At COS	4	8.0
Telephone	12	24.0
In the Community	8	16.0
None	26	52.0
Level of Contact that Client has with Family and/or Significant Other		
n = 50	Frequency	Percent
Almost Always	6	12.0
Regularly, Weekly	16	32.0
Sometimes, Monthly	3	6.0
Sporadic, Holidays	3	6.0
Almost never, once a year	5	10.0
None	17	34.0

Table 8. Linkage to COS/HOPE Team Services in the Homeless Population during First Contact

Who Requested COS/HOPE Team Services		
n = 25	Frequency	Percent
Staff at Shelter	8	32.0
Consumer	1	4.0
Grady Health System	9	36.0
Georgia Regional Hospital	2	8.0
Jail	2	8.0
Community Professional	2	8.0
Church	1	4.0
Service Provided by the COS/HOPE Team		
n = 25	Frequency	Percent
Assessment	25	100.0
Therapy	14	56.0
Prescription	11	44.0
Medication	12	48.0
Referral	23	92.0
Lab Work	1	4.0
Consumer Return for Follow-up Appointment by COS/HOPE Team		
n = 25	Frequency	Percent
Yes	25	100.0

Table 9. Status and Rate of COS Consumer Referrals during a Five Month Interval (December 2001 to April 2002)

Staff Behavior at Time of Referral		
n = 25	Frequency	Percent
Gave referral verbally	6	24.0
Helped make appointment	12	48.0
Accompanied consumer	1	4.0
Total	19	76.0
Consumer Behavior at Time of Referral		
n = 25	Frequency	Percent
Accepted help	11	44.0
Refused services	1	4.0
Not indicated	7	28.0
Total	19	76.0
Outcome of Referral		
n = 25	Frequency	Percent
Check restarted	1	4.0
Obtained housing	2	8.0
Obtained medical care	5	20.0
Did not keep appointment	1	4.0
Refused referral	1	4.0
Does not indicate outcome	9	36.0
Total	19	76.0

Table 10. Case Composition and Discharge Summaries

Initial Referral Source		
n = 25	Frequency	Percent
Shelter Staff	2	8.0
Grady Health System	12	48.0
Georgia Regional Hospital	10	40.0
O’Hearn House	1	4.0
Total	25	100.00
Reason for Discharge		
n = 25	Frequency	Percent
Completed Program	7	28.0
Receiving Other Services	2	8.0
At Large	2	8.0
Refused Services	12	48.0
Deceased	2	8.0
Total	25	100.0
Axis One Diagnosis		
n = 25	Frequency	Percent
293 (Psychotic Disorder)	1	4.0
295 (Schizophrenia)	16	64.0
296 (Mood Disorder)	6	24.0
304 (Substance Use Disorder)	1	4.0
311 (Depressive Disorder)	1	4.0

CHAPTER 5

RECOMMENDATIONS AND CONCLUSION

This section contains the research study evaluation questions combined with recommendations for improvement of service delivery in each specific question area. In addition to those specific improvements, a list of recommendations concerning other aspects of the COS program not directly addressed by the program evaluation questions but discovered during the course of this evaluation and found to be relevant to social work direct practice and social work service delivery is provided. The questions are listed as Q1, Q2a, Q2b, Q2c, Q2d, Q3, and Q4 with the recommendations listed as RCM1, RCM2, RCM3, RCM4, RCM5, RCM6, and RCM7 respectively.

Q1. Does the quality of life improve for COS consumers?

RCM1. The recommendation for improvement in the self-report of quality of life by COS consumers using the BASIS-32 are: The clinical staff should attend regular training on understanding and utilization of the BASIS-32 within a clinical setting. Clinical records indicate (through lack of documentation) no review of the scores on the BASIS 32 with the consumer or treatment team. Integration or modification of the treatment plan to reflect incorporation of information provided by the consumer should be a regular and consistent process. Appropriate use of the BASIS-32 is reflected by evaluation on any score of 4 points or higher on a subscale. An information packet may be obtained by sending $30 to: Dr. Susan Eisen, McLean Hospital, 115 Mill Street, Belmont, MA 02178. The information packet contains information pertinent to administration, scoring and interpretation of the BASIS-32. Regular training in the administration, scoring, and clinical use of the BASIS-32 is essential for this instrument to be a useful tool in assessment of service delivery efficacy.

Q2. What is the frequency of success or effectiveness that is achieved concerning the stated goals of COS programs in these specific areas:

a) Reduction of hospitalization in Elderly population

RCM2. Recommendation for improvement in reduction of hospitalization in the Elderly population: Increase clinical and physician contact, assessment, and treatment. Medicaid standards of care should be considered (as a minimum) along with clinical training, systematic and periodic chart reviews to uphold these standards.

b) Flexibility and frequency of Interventions (milieu of treatment, meeting places and, forms of contact)

RCM3. Recommendations for improvement in flexibility and frequency of interventions: 1) Active solicitation from consumer as to preference of meeting places; 2) increase clinical and physician contact to Medicaid standards; 3) LCSW caseload supervision; evaluation of caseloads; 4) clinical training on consumer engagement in treatment process; and, 5) clinical record maintenance training.

c) Family and Significant Other contacts

RCM4. Recommendation for improvement in family and significant other contacts: Clinical training on consumer engagement in treatment process, active solicitation concerning development or maintenance of consumer's ties with the community, treatment plan development in the area, and clinical record documentation of this process.

d) Linkage to COS/HOPE Team services in Homeless population

RCM5. The data collected for this service indicate that linkage to COS/HOPE Team service and other referral services are excellent. Follow-up services are functioning at maximum capacity. There are no additional recommendations at this time.

Q3. What is the status and rate at which COS consumers obtain referral services?

RCM6. Recommendation for improvement in consumers obtaining referral services: 1) LCSW clinical supervision to assure that all possible referrals are offered to the consumer and all avenues are explored to insure that consumer obtains services; 2) documentation of outcomes of referrals; and 3) clinical record maintenance training.

Q4. What is the case composition and reasons for COS program discharges?

RCM7.Recommendation for improvement in consumer discharge from COS discharge: 1) Clinical training on consumer engagement in treatment process; 2) documentation of follow-up once referral is received; and, 3) clinical record maintenance training.

Additional general recommendations developed as a result of the study are as follows:

1) Medicaid standards training for clinical care to insure compliance and understanding service delivery of minimum care requirements.

2) External (non-COS personnel) chart reviews to insure compliance with service delivery of minimum care requirements.
3) Evaluation and redistribution of caseloads with particular emphasis as to severity of illness, frequency of intervention, and additional time spent on case management issues.
4) Consumers that are 'at large' after certain period of time (utilize Medicaid standards) should be placed in an inactive status and not counted on active caseloads.
5) Clinical clarification of the term 'visit only'. The term 'case management' or 'supportive therapy' should be considered for non-psychiatric interventions instead.
6) Clinical training on the development of treatment plans and appropriate goals for this population of consumer.
7) Documentation of all community visits with clear statement of justification of visit as it relates to the treatment plan.
8) Discharge documentation and closing a chart should be done when a consumer is known to be deceased.
9) Timely (within 5 working days) discharge documentation (including final status) when consumer is transferred to another service. Consumers should not be kept on active status once the treating psychiatrist signs the discharge/transfer papers (Medicaid standards).
10) Timely (within 2 working days) face-to-face contact with the psychiatrist and clinician at the time of the issuance of a prescription (especially narcotics).
11) Destroying out-of-date prescriptions left in records with proper documentation to follow the act.
12) Specific training in the area of documentation within the records to address:
    a) pencil use in chart;

b) post it notes in chart;
c) proper writing and placement of progress notes (chronological order – do not back date any information);
d) writing on sides, top, or back of forms and progress notes;
e) marking out unused spaces in progress notes and forms;
f) proper dating of ‘added information’ once form has original signature and date;
g) all signatures accompanied by date;
h) compliance in update of chart forms including but not limited to: consent for treatment, AIMS, treatment plans, BAISI-32, and all other forms required to insure proper treatment;
i) stamp ‘RECEIVED’ date on incoming documents especially lab work and external government forms.

Grady Health System COS and the Best Practices Model

The Grady Health Services COS has a well-established relationship within the communities they provide services. The COS also has a good working relationship with the agencies in the Safe Haven/Permanent Housing Demonstration Project for which they provide mental health, social work, and case management services to the homeless/near homeless population. These agencies also report an informal relationship with each other that is working well. Lines of communication with key personnel are open with the understood best interest of the consumer as the foundation of the professional relationship. Although the informal relationship pattern is essential to the success of any multi-agency process, it does not always ensure longevity of the program; therefore, the following suggestions are provided to move this multi-agency project closer to the ‘Best Practices’ model of service delivery to the homeless/near homeless population.

The first recommendation is for the creation of an Interagency Planning Body (consisting of key persons from each agency that provide services within this project) to approve a common mission, set goals, develop operation policies and procedures, and provide a final decision-making entity. In conjunction with the creation of an Interagency Planning Body, developing a centralized or responsible party for the purpose of gathering data and streamlining the information and referral process for the consumer groups served would improve service delivery and reduce overlap of services. The Grady Health System COS would be an obvious recommendation for a centralized or responsible party for this process. The COS staff already performs the task of maintaining medical records; therefore, merging data and referral requirements would lend itself easily to this established process. Next, the development universal definitions for service delivery products would reduce overlap of services and improve accountability. Some examples of service delivery products needing defining includes such words as ‘outreach’, ‘encounter’, ‘enrolled’, ‘case management’, ‘treatment’, and ‘therapy.’ Each agency within the collaboration has a different understanding of these terms. In order to improve service delivery, a common understanding of service delivery products is necessary and prudent. As the CoC deals with its day to day management, the models of service delivery will be a common issue. It is recommended for this particular population that evaluating the potential of adoption of the ‘Harm Reduction’ model concerning substance use/abuse. Appropriate incorporation of this model demonstrates a cost effective response to the revolving syndrome of losing residence, going to jail, and returning to street life for substance abusers (Culhane et al., 2001; Minkoff, 1996; Shern et al., 1997).

A final recommendation is to develop universal efficacy markers to track for ongoing program evaluation. The following efficacy indicators are taken from the literature and are considered both cost effective indicators by service providers and quality of life indicators by consumers (Interagency Council on the Homeless, 2002; Proscio, 2000):

1) Demographic information to include: age, race, veteran status, frequency of homelessness, duration of homelessness, family makeup, birthplace, education, health status);
2) Emergency room use (prior to program and during program for comparison purposes);
3) Medical hospitalization (prior to program and during program for comparison purposes);
4) Psychiatric hospitalization (prior to program and during program for comparison purposes; length of stay; reasons for hospitalization; type of facility);
5) Incarcerations (prior to program and during program for comparison purposes; length of stay; reasons for incarceration; type of facility);
6) Institutionalization at Georgia Regional (prior to program and during program for comparison purposes);
7) Movement toward self-sufficiency (disability applications for SSI or SSD, job training, hobbies, self-care training, medication management).

Follow-up to Recommendations

The results of this research study and the concluding recommendations were presented to the Director of Mental Health Services at Grady Health System, Dr. Keith Woods in the spring of 2003. As a direct result of this program evaluation, several changes were made over the course of the following year. First, the medical director was removed and replaced with a psychiatrist specializing in treatment for this consumer group. Next, Medicaid standards for documentation of treatment and (most importantly), levels of care were adopted as a minimum standard. Then, each clinician was individually assessed and her cases reviewed by the new medical director and LCSW supervisor. Subsequent team training in areas of service delivery, documentation, and clinical care was instituted over the following year. Several clinicians were re-assigned to others areas of hospital care not requiring direct therapy skills. Finally, an audit of charts was done to itemize and correct the documentation problems illuminated by the program evaluation.

Subsequent evaluations of service delivery for the COS were also recommended. The next evaluation should consider a larger sample size and possibly a different design (a repeated measures design has a greater potential to track changes in a chronic population). It is unclear as to whether a full program evaluation will take place; however, systematic and periodic chart reviews have been instituted since the adoption of Medicaid standards.

Conclusion

This external, confirmative, objectives-oriented program evaluation elucidated several service delivery problem areas in addition to validating areas were service delivery is excellent. First, the frequency of clinical and psychiatric intervention provided to the COS consumer is below Medicaid standards and below what this researcher considers being standard community care. Medicaid standards are by definition, the minimum state allowable requirements for service delivery. This sub-standard service delivery may also attribute to the lack of improvement on consumer self-report of the BASIS-32 and a lack of change (decrease) in the hospitalization rate of the elderly COS consumer. In addition, the pervasive lack of documentation within the consumer’s record leaves questionable proof of clinical work that may have occurred such as referrals, family/significant other contacts, community visits, or therapy toward treatment plan goals. Furthermore, poor documentation techniques allow the question of authenticity and accuracy to present itself to an outside review of the chart.

Through the process of triangulation (Mills, 2003) – the lack of improvement on self-report of the BASIS-32 plus no positive change (decrease) in hospitalization rate of geriatric consumers, added to the sub-standard clinical contact – the efficacy of the current service delivery of the COS is considered seriously defective by this researcher and the community standard (Kaplan and Sadock, 1981; Stein & Santos, 1998). As a result of this program evaluation, this particular model of service delivery should be seriously scrutinized for future viability. While this aspect of the COS bears reassessment, the integration of the HOPE model (a model having some similarities to the Assertive Community Treatment [ACT] model (Stein & Santos, 1998)) to service the homeless/near homeless population suffering from serious mental illnesses does demonstrate the long-term commitment that the Grady Health System COS has to provides quality services to its diverse consumer population. The COS/HOPE Team provides above standard clinical, psychiatric, and case management care as demonstrated by data gathered concerning first contact and referrals provided to the consumer. Proper implementation of this model of service delivery also resulted in excellent COS/HOPE Team consumer follow-up rates. A strong recommendation stemming from this research study is to consider the incorporation of applicable aspects of an ACT-like model used by the COS/HOPE Team throughout the COS to better serve all its consumers.

The external relationship issues of the COSs participation with the Safe Haven/Permanent Housing Demonstration Project are more difficult to change or influence due to the complexity of the collaboration and the different funding streams of each participating agency. Although the COS can make recommendations on the organization of the collaboration, changes in the leadership, mission, and information systems, the necessary power to make these changes occur may need to come from the state or federal level of leadership.

Homelessness and the serious physical, mental, and social issues that enmesh this problem may never completely resolve itself. The belief that the homeless are just lacking permanent shelter is a horrible simplification of the issues surrounding homelessness. The lack of momentum to sustain stable housing is a final visible result of the culmination of catastrophic insults rendering the individual incapable of any level of self-determination. What is done as a social community to reduce and prevent this problem is a strong measure of humanity. There are practical and efficacious steps that can be taken to improve service delivery to this population. This study - and the recommendations that followed, is an example of some of the steps that are grounded in direct application and research concerning this population. The homeless population has already established the need for long-term care. Consistent and systematic evaluations of service delivery will build on and continue to develop and expand efficacy in this area.

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APPENDIX A

REFERRAL PROCESS INFORMATION

FAMILY AND SIGNIFICANT OTHER CONTACTS

(TABULATE FOR A FIVE MONTH PERIOD)

Referral Process Information

Family and Significant Other Contacts (Tabulate for a five month period)

1. Who recommended/suggested the family/so contact?

   1. staff 2. client 3. family/so 4. other 5.____________

2. What was the form of contact?

   1. f-t-f at COS 2. phone message 3. phone conversation 4. letter 5. f-t-f community

   6. other 7. ______________

3. According to the records, does this person (client) have contact with family/so?

1. Almost always	2. regular contact	3. sometimes	4. sporadic	5. almost never
(daily)	(weekly)	(monthly)	(holidays)	(once a year)

   6. never

APPENDIX B

INDIVIDUAL CLIENT INTERVENTIONS

(TABULATE OVER A FIVE MONTH PERIOD)

Individual Client Interventions (Tabulate over a five month period)

1. Where did meeting take place?

   1. COS 2. residence 3. community meeting place 4. other 5. ____________

2. What type of meeting was it?

   1. psychiatrist 2. clinical 3. shot 4. community 5. telephone 6. other

APPENDIX C

GERIATRIC HOSPITALIZATIONS RATES

(TABULATE FOR A ONE YEAR PERIOD)

Geriatric Hospitalizations Rates (Tabulate for a one year period)

	Admit	Discharge	LOS	Type (Psy/Med)	COS visit
1.					
2.					
3.					
4.					
5.					

Geriatric Hospitalizations Rates prior to COS admission (Tabulate for a one year period)

	Admit	Discharge	LOS	Type (Psy/Med)
6.				
7.				
8.				
9.				

APPENDIX D

HOMELESS COS/ACT ACCESS INVENTORY DURING FIRST CONTACT

Homeless COS/ACT Access Inventory During First Contact

1. Who requested/suggested Mental Health services?

   1. Staff at Day shelter 2. Staff at Night shelter 3. Client 4. Family/SO 5. Other

   6. __________________

2. What type of Mental Health service was received at contact?

   1. Therapy 2. Prescription 3. Referral 4. Other assistance 5. Medication

   6.Vouchers 7. Other 8. ____________

3. Does the record reflect that client returned for a follow-up appointment? Yes/No

4. Does the record reflect that client obtained referral assistance? Yes/No

APPENDIX E

REFERRAL INFORMATION

Referral Information

1. Referred to:
   a. b. c. d. e.

2. Staff behavior:
   a. gave referral verbally b. helped make appointment c. set up transportation
   d. took client e. other f. _______________

3. Client behavior:
   a. made appointment independently b. accepted help to make appointment
   c. refused referral
4. Does chart indicate outcome? List outcome.

APPENDIX F

DISCHARGE INFORMATION

Discharge Information

1. Client initially referred from:

2. Date of first contact:

3. Discharge date:

4. LOS:

5. Reason for discharge:
   a. completed program b. refused services c. receiving other services d. at large
   e. deceased f. other g. ________________

6. Referred at discharge to:

7. Does record indicate that client made transition to other services after discharge?

Case Composition:

1. A. Axis 1:

   B. Axis 2:

   C. Axis 3:

   D. Axis 4:

   E. Axis 5:

2. Demographic Information:
   A. Age B. Race C. Education D. Work History

   E. Income F. Family help G. Residence

APPENDIX G

BASIS-32

BEHAVIOR AND SYMPTOM IDENTIFICATION SCALE

BASIS-32

Behavior and Symptom Identification Scale

* The BASIS-32 is not in the public domain, but providers who use the scale to assess their clients' outcomes or for research purposes may use the scale free of charge. The content of the scale is copyrighted. To obtain an information packet, send $30 dollars to Dr. Susan Eisen, McLean Hospital, 115 Mill Street, Belmont, MA 02178 (Russo et al., 1997).Copyright 1985, Evaluative Services Unit, McLean Hospital

This form and information is filled out and maintained by the Community Outreach Services.

APPENDIX H

CONSENT FORM

CONSENT FORM *January, 2002*

I agree to take part in a research study titled Grady Health System Community Outreach Services: Evaluation of Program Implementation, which is being conducted by Denise M. Green, LCSW, PhD. student, School of Social Work at Tucker Hall, UGA, phone number 706-542-5470, under the supervision of Dr. Larry Nackerud, Assistant Dean, School of Social Work at Tucker Hall, UGA, phone number 706-542-5470 and Grady Health Systems Community Outreach Services, under the supervision of Shelia Beckum-Head, Director, Community Outreach Services, phone number 404-616-9999.

I do not have to take part in this study. I can stop taking part at any time without giving any reason, and without penalty. I can request to skip questions that I do not want to answer. Non-participation in this study will not affect my treatment at Community Outreach Services. I can ask to have information related to me returned to me, removed from the research records, or destroyed.

The purpose of this study is to evaluate services provided by Grady Health System Community Outreach Services. Specifically, do I receive services offered by the COS and do these services improve my quality of life?

I may not benefit directly from this research. However, my participation in this research may lead to information that could help the staff and managers of Community Outreach Services improve the quality of services provided. My participation may also lead to information that could help staff and managers of similar programs improve the quality of services they provided to the community.

A researcher will explain the purpose of the study, the information to be gathered and the procedure for gathering the information. After all questions have been answered and consent forms signed, I may be asked to fill out a survey provided by the researcher, asked some specific questions concerning services provided by the COS by the researcher, or my record may be reviewed by the researcher. There will also be questions related to substance abuse. No discomfort or stresses are expected. The entire session is expected to last 45 min. There will be no videotaping, tape recording or picture taking.

No risks are expected. My participation or non-participation will have no impact on the services provided to me by Grady Health System.

All information that is obtained in connection with this study and that can be identified with me will remain confidential and will be disclosed only with my permission or as required by law.

The researcher will answer any further questions about the research, now or during the course of the project, and can be reached at: 706-542-5470 or 404-616-9999. Ask for Denise M. Green.

My signature below indicates that the researcher has answered all of my questions to my satisfaction and that I consent to volunteer for this study. I have been given a copy of this form. I may also have a copy of any other information provided by me at my request.

____
Signature of Researcher/Date or Signature of Witness/Date

____
Signature of Participant/Date

For questions or problems about your rights please call or write: Dr. Christina A. Joseph, Human Subjects Office, University of Georgia, 606A Boyd Graduate Studies Research Center, Athens, Georgia 30602-7411: Telephone (706) 542-6514; E-mail Address IRB@uga.edu.

OR

If you have questions about your rights as a participant in this study, you may contact Dr. Karen Hegtvedt, Chair, Social, Humanist, and Behavioral Institutional Review, which oversees the protection of human research participants. She can be reached at 404-727-7517 or khegtv@emory.edu.

APPENDIX I

SPSS DATA

SPSS Data

Individual Client Outcomes

1	.	3	2	2	9	1	.	.	.
1	4	4	2	4	1	.	.	.	.
.	.	2	2	1	.	.	.	.	.
.	4	4	.	2	.	.	.	.	.
.	.	3	5	.	.	.	.	.	.
.	.	1	1	15	3	.	.	.	1
.	.	1	1	1	.	.	.	.	.
.	.	5	5	.	.	.	.	.	1
2	.	3	4	3	6	.	.	.	.
.	.	2	3	.	.	.	.	.	.
.	.	2	3	.	.	.	.	.	.
.	.	.	2	.	.	.	.	.	.
.	.	3	1	.	.	.	.	.	.
.	.	.	3	1	1	.	.	.	.
3	.	2	2	.	.	.	.	.	.
.	1	3	2	2	.	.	.	.	.
.	2	2	2	.	.	.	.	.	.
4	1	2	3	.	.	.	.	.	.
1	4	3	3	.	1	.	.	.	.
.	.	.	1	6	2	.	.	.	.
.	.	.	.	.	.	.	.	12	.
3	.	.	2	5	.	.	.	.	.
1	.	2	1	.	2	.	.	.	.
2	.	4	2	5	.	.	.	.	.
.	.	3	1	.	1	.	.	.	2
.	.	.	.	3	3	.	.	.	.
2	.	2	2	2	2	.	.	.	.
.	.	2	.	.	1	1	.	.	.
.	.	.	.	.	1	.	.	.	.
.	.	3	.	.	.	.	.	.	.
.	.	.	2	.	5	.	.	.	.
1	.	5	7	.	1	.	.	.	.
.	.	2	3	.	.	.	.	2	.
1	.	1	1	1	1	1	.	.	.
2	3	6	4	.	1	.	.	.	.
.	.	1	1	.	.	1	.	.	.
.	.	1	2	1	3	1	.	.	.
.	.	.	.	.	6	1	.	.	.
.	.	3	1	5	2	.	.	.	.
.	.	1	5	.	.	.	.	3	.

Individual Client Outcomes

```
.     .     1     .     .     4     .     .     .     .

.     .     1     2     1     6     .     .     .     .
.     .     2     .     .     1     .     .     .     .
.     .     7     2     .     .     1     .     .     .
.     .     .     .     2     3     .     .     .     .
.     .     .     .     1     6     1     .     .     .
.     4     4     1     .     1     1     .     .     .
.     .     3     .     .     .     .     .     .     .
1     .     .     1     .     7     .     .     .     .
```

Individual Client Outcomes

```
social security 2     2     check restarted       .     .40   1.20  .     .     .
      .     .     .     .
medical evaluation    1     2     pt went to clinic     .20   .     .60   .40   .40
      1.80  .20   .     .     .
no referrals    .     .           .20   .80   .80   .40   .80   .20   .     .
      .     .
medical evaluation    2     2     pt went to clinic     .     .     .40   .40   .20
      .     .     .     .     .
no referrals    .     .           .     .80   .80   .     .40   .     .     .
      .     .
Legal Aid       1     4     does not indicate outcome     .     .     .60   1.00  .
      .     .     .     .     .
Housing         2     2     pt recieved housing   .     .     .20   .20   3.00  .60
      .     .     .     .20
medical evaluation    2     2     pt went to clinic     .     .     .20   .20   .20
      .     .     .     .     .
medical evaluation    2     4     does not indicate outcome     .     .     1.00  1.00
      .     .     .     .     .     .20
medical evaluation    1     4     does not indicate outcome     .40   .     .60   .80
      .60   1.20  .     .     .     .
medical evauation     2     2     does not indicate outcome     .     .     .40   .60
      .     .     .     .     .     .
Florida Hall    1     4     does not indicate outcome     .     .     .40   .60   .
      .     .     .     .     .
Florida Hall    1     4     does not indicate outcome     .     .     .     .40   .
      .     .     .     .     .
Program Intake (Bright Beginni    2     4     does not indicate outcome     .     .
      .60   .20   .     .     .     .     .     .
no referrals    .     .           .     .     .     .60   .20   .20   .     .
      .     .
```

```
case management         2       2       does not indicate outcome       .60     .       .40     .40
        .       .       .       .       .       .
no referrals    .       .               .       .20     .60     .40     .40     .       .       .
        .       .
no referrals    .       .               .       .40     .40     .40     .       .       .       .
        .       .
transportation  1       3       refused referral        .80     .20     .40     .60     .       .
        .       .       .       .
Mental Health Center    2       2       did not keep appointment        .20     .80     .60     .60
        .       .20     .       .       .       .

medical evaluation      2       2       pt went to clinic       .       .       .       .20     1.20
        .40     .       .       .       .
no referrals    .       .               .       .       .       .       .       .       .       .
        2.40    .
medical evaluation      4       2       pt went to clinic       .60     .       .       .40     1.00
        .       .       .       .       .
Social Security         2       4       does not indicate outcome       .20     .       .40     .20
        .       .40     .       .       .       .
Housing         2       2       pt recieved housing     .40     .       .80     .40     1.00    .
        .       .       .       .
        .       .               .       .       .60     .20     .       .20     .       .       .
        .40
        .       .               .       .       .       .       .60     .60     .       .       .
        .
        .       .               .40     .       .40     .40     .40     .40     .       .       .
        .
        .       .               .       .       .40     .       .       .20     .20     .       .
        .
        .       .               .       .       .       .       .       .20     .       .       .
        .
        .       .               .       .       .60     .       .       .       .       .       .
        .
        .       .               .       .       .       .40     .       1.00    .       .       .
        .
        .       .               .20     .       1.00    1.40    .       .20     .       .       .
        .
        .       .               .       .       .40     .60     .       .       .       .       .40
        .
        .       .               .20     .       .20     .20     .20     .20     .20     .       .
        .
        .       .               .40     .60     1.20    .80     .       .20     .       .       .
        .
        .       .               .       .       .20     .20     .       .       .20     .       .
        .
```

.	.	.	.	.20	.40	.20	.60	.20	.	.	.
.	.	.	.	.	.	.	1.20	.20	.	.	.
.	.	.	.	.60	.20	1.00	.40	.	.	.	.
.	.	.	.	.20	1.00	.	.	.	.	.60	.

Individual Client Outcomes

.	.	.	.	.20	.	.	.80	.	.	.	.
.	.	.	.	.20	.40	.20	1.20	.	.	.	.
.	.	.	.	.40	.	.	.20	.	.	.	.
.	.	.	.	1.40	.40	.	.	.20	.	.	.
.	.	.	.	.	.	.40	.60	.	.	.	.
.	.	.	.	.	.	.20	1.20	.20	.	.	.
.	.	.	.80	.80	.20	.	.20	.20	.	.	.
.	.	.	.	.60	.	.	.	.	.	.	.
.	.	.20	.	.	.20	.	1.40	.	.	.	.

BASIS 32

1	1	5	2	0	1	0	0	2	0	295.90 none noted
1	19	1	17	1	6	2	5	1	7	298.50 h/o cocaine abu
3	5	4	4	2	1	0	0	0	1	295.30 none noted
25	24	18	18	11	11	5	5	3	3	295.30 cocaine abuse
0	0	3	0	1	0	2	2	1	1	295.90 cocaine abuse
7	7	18	18	9	9	3	3	2	2	295.30 none noted
0	0	0	0	2	0	1	0	0	0	295.70 none noted
9	0	8	5	13	8	4	4	8	2	295.70 none noted
24	24	23	24	15	20	9	16	9	20	295.70 none noted
1	1	5	5	4	4	0	0	3	3	296.30 none noted
1	0	4	1	4	0	0	1	0	1	296.60 h/o cocaine abu
4	4	3	3	0	0	5	5	2	2	295.90 none noted
0	0	0	0	0	0	0	0	0	0	295.90 none noted

12	12	13	13	19	19	3	3	8	8	295.30 polysubstance
0	0	0	0	0	0	0	0	0	0	295.30 crack cocai
0	0	0	0	0	0	0	0	0	0	295.30 crack cocain
0	0	0	0	2	0	1	0	0	0	295.30 none noted
2	9	5	11	5	5	0	3	0	1	296.60 none noted
4	11	5	11	9	15	4	10	6	3	296.22 none noted
12	15	7	9	4	10	0	0	4	1	293.81 crack cocain
8	10	2	7	5	10	5	5	0	6	296.60 none noted
21	21	15	15	16	16	7	7	6	6	295.30 polysubstance a
2	0	4	0	2	0	1	0	2	2	295.70 none noted
3	5	6	2	5	2	0	0	4	2	296.60 none noted
0	0	1	1	0	0	0	0	0	0	295.70 none noted
23	26	23	25	5	13	8	16	9	11	295.70 none noted
1	4	5	8	4	5	0	0	3	1	293.30 none noted
0	0	0	0	0	2	2	0	0	2	295.30 crack cocain
0	0	0	0	1	0	2	1	2	0	295.70 none noted
1	0	1	0	6	2	0	1	7	1	296.34 THC abuse
2	4	5	0	4	0	3	0	2	0	295.90 crack cocain
0	0	1	0	1	0	1	0	0	0	295.90 none noted
0	6	1	9	1	2	1	2	1	3	295.90 none noted
0	4	0	0	0	4	9	9	2	6	295.70 304.80
0	0	1	0	1	1	0	1	0	0	295.70 none noted
2	0	3	2	4	2	0	0	1	0	295.70 none noted
4	4	6	0	0	0	2	0	0	0	295.30 none noted
0	0	0	0	0	1	0	0	0	0	295.70 none noted
0	3	2	7	1	1	0	2	0	3	295.60 crack cocaine

BASIS 32

3	21	0	21	8	16	9	10	12	13	295.30 none noted
0	4	0	2	0	0	0	0	0	2	295.30 none noted
17	17	18	18	16	16	7	7	2	2	295.90 none noted
2	2	6	6	6	6	3	3	11	11	296.10 cocaine abuse
2	3	0	0	2	2	0	0	0	0	295.30 none noted
0	0	0	3	0	6	0	3	0	8	295.90 crack cocain
0	3	0	2	2	2	0	0	0	5	295.30 crack cocain
2	0	3	0	0	0	1	0	0	0	295.70 crack cocaine
9	13	3	15	13	13	5	9	0	5	295.70 none noted
4	4	1	1	1	3	2	0	0	2	295.30 crack cocain
12	22	7	21	8	18	2	9	0	6	295.90 none noted

Discharge Information

Georgia Regional Hospital 06/09/00 04/26/01 10 6 Mental Health Center
1.00 296.60 71.09
Grady Memorial Hospital 10/01/99 01/18/00 3 4 NA 2.00 296.22
.
Grady Memorial Hospital 11/08/01 . . 5 Deceased 1.00 295.70
.
Grady Memorial Hospital 03/10/95 05/16/00 62 2 Grady Day Tx 2.00
296.40 .
Day Shelter 05/19/98 12/07/99 19 2 Florida Hall 2.00 295.30 .
Florida Hall 09/18/91 01/03/01 108 1 Grady Day Tx 2.00 296.30 .
Florida Hall 01/29/97 01/19/01 48 2 Access 2.00 295.90 .
Georgia Regional Hospital 10/22/90 08/14/01 130 5 NA 3.00 296.70
.
Georgia Regional Hospital 10/25/94 01/03/01 75 1 Florida Hall 2.00
293.90 .
Georgia Regional Hospital 08/09/86 05/04/00 165 2 NA 2.00 295.30
.
O'Hearn House 07/21/99 02/09/01 19 3 Mental Health Center 2.00
295.30 .
Grady Memorial Hospital 02/11/99 03/24/99 1 2 NA 2.00 304.80
.
Grady Memorial Hospital 07/14/00 04/27/01 9 2 NA 2.00 295.30
.
Florida Hall 09/02/99 10/10/00 13 2 Mental Health Center 2.00 295.90
.
Georgia Regional Hospital 03/10/00 08/22/00 5 2 Access 2.00 295.70
.
Grady Memorial Hospital 03/13/92 02/07/99 11 1 Florida Hall 1.00
295.90 .
Georgial Regional Hospital 02/15/96 03/24/00 49 1 MH Center 2.00
296.25 .
Grady Memorial Hospital 10/26/99 05/16/01 19 2 MH Center 2.00
295.70 .
Georgia Regional Hospital 12/03/96 05/04/01 53 1 MH Center 2.00
311.00 .
Day Shelter 05/10/00 07/31/00 2 3 MH Center 2.00 295.70 .
Georgia Regional Hospital 12/17/98 08/11/99 8 2 Georgia Regional
Hospital 1.00 295.30 .
Georgia Regional Hospital 08/14/96 05/01/01 57 2 Access 1.00 295.90
.
Georgia Regional Hospital 09/11/87 08/06/01 167 1 Nursing Home 1.00
295.70 .

Discharge Information

Florida Hall	02/22/96	03/11/02	73	1	Florida Hall	2.00	295.30 .
Grady Memorial Hospital	01/05/99	06/01/00	17	2	NA	2.00	295.90 .

Discharge Information

1970	2	2	4	3	32.00
1961	2	2	4	1	41.00
1941	1	2	4	3	61.00
1976	2	2	4	1	26.00
1964	1	2	4	2	38.00
1947	1	2	4	2	55.00
1959	1	1	4	3	43.00
1950	1	2	4	3	52.00
1955	1	2	4	1	47.00
1958	1	2	4	1	44.00
1949	1	2	4	3	53.00
1955	1	2	4	3	47.00
1952	1	2	4	3	50.00
1951	1	2	4	3	51.00
1949	1	1	4	3	53.00
1952	2	2	4	1	50.00
1963	1	1	4	1	39.00
1942	1	2	4	2	60.00
1948	1	2	4	1	54.00
1957	1	2	4	1	45.00
1971	2	2	4	3	31.00
1949	2	2	4	3	53.00
1949	2	1	4	1	53.00
1954	1	2	4	1	48.00
1972	2	2	4	1	30.00

Family and Significant Other Contact

5	7	5
3	2	2
1	5	2
1	1	1
34	15	2
5	7	6
5	7	6
1	5	5
5	7	4

5	7	1
2	25	3
5	7	1
5	7	6
5	7	6
5	7	5
5	7	6
3	2	2
3	1	1
2	5	5
2	3	2
3	5	1
5	7	2
5	7	1
5	7	6
2	7	2
2	3	2
5	7	6
3	2	2
3	3	3
5	7	6
5	7	6
5	7	6
1	5	2
5	7	6
5	7	6
5	7	6
5	7	6
5	7	6
3	12	4
5	7	5
1	1	2
1	3	2

Family and Significant Other Contact

1	5	2
1	2	2
1	3	4
5	7	6
1	3	3
1	2	2
5	7	6
1	2	2

Elderly Hospitalization Rate

60	0	1
60	3	0
58	0	0
58	0	0
56	0	0
53	0	0
60	0	1
71	1	0
64	4	1
59	1	4
53	0	0
55	0	2
50	1	1
64	0	0
59	2	2
53	0	0
61	4	2
58	0	1
57	0	1
74	0	0
73	0	0
56	0	0
56	3	1
53	0	0
54	2	1
50	0	1
55	0	0
52	0	1
58	1	1
60	0	0
51	1	0
51	0	0
63	0	0
55	0	0
86	1	0
51	0	0
60	2	1
59	0	0
59	1	1
62	1	1
63	0	1
55	2	1

Elderly Hospitalization Rate

50	1	1
54	0	0
81	1	0
51	0	0
61	0	1
61	0	0
67	1	2
52	1	1

Homeless Mental Health Access

1	abdf	1	1
1	abdf	1	1
6	bdf	1	1
5	acdf	1	1
1	cf	1	1
5	f	1	1
5	cf	1	1
5	bdf	1	1
5	af	1	1
8	adf	1	1
3	f	1	1
7	f	1	1
1	abcf	1	1
1	f	1	1
5	abcdf	1	1
1	acdf	1	1
9	acf	1	1
5	bf	1	2
1	abcdf	1	1
5	adf	1	1
7	abcf	1	1
2	f	1	1
5	bcdf	1	1
6	af	1	2
8	abdfg	1	1

APPENDIX J

CODE BOOK

Code Book

Individual Client Outcomes

File Information

```
            List of variables on the working file

Name
Position

NAME      name of client
1
          Measurement Level: Nominal
          Column Width: 20  Alignment: Left
          Print Format: A20
          Write Format: A20

VISITONL  visit only
4
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

SHOT      Deconate Shot
5
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

THERAPY   therapy visits
6
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

MEDVISIT  medication visit
7
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8
```

Individual Client Outcomes

```
COMM      community visit
8
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

TELEPHO   telephone contact
9
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right

          Print Format: F8
          Write Format: F8

CASE      case presentation
10
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

CASEMANA  case management
11
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

GROUP     Group Therapy Session
12
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

OTHER     other type of contact
13
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8
```

Individual Client Outcomes

```
REFERRED  referred to
14
          Measurement Level: Nominal
          Column Width: 30  Alignment: Left
          Print Format: A30
          Write Format: A30

STAFF     staff behavior
18
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

          Value    Label

              1    gave referral verbally
              2    helped make appointment
              3    set up transportation
              4    took client

CLIENT    client behavior
19
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

          Value    Label

              1    made appointment independantly
              2    accepted help to make appointment
              3    refused services
              4    not indicated

OUTCOME
20
          Measurement Level: Nominal
          Column Width: 30  Alignment: Center
          Print Format: A30
          Write Format: A30
```

Individual Client Outcomes

```
VISITAVE
24
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8.2
          Write Format: F8.2

SHOTAVER
25
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8.2
          Write Format: F8.2

THERAVER
26
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8.2
          Write Format: F8.2

      MEDAVERA
27
    Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8.2
          Write Format: F8.2

COMMAVER
28
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8.2
          Write Format: F8.2

TELEAVER
29
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8.2
          Write Format: F8.2
```

Individual Client Outcomes

```
CASEAVER
30
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8.2
          Write Format: F8.


MANAVERA
31
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8.2
          Write Format: F8.2

GROUPAVE
32
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8.2
          Write Format: F8.2

OTHERAVE
33
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8.2
          Write Format: F8.2
```

BASIS 32

File Information

```
            List of variables on the working file

Name
Position

CLIENT    client name
1
          Measurement Level: Nominal
          Column Width: 8  Alignment: Left
          Print Format: A8
          Write Format: A8
```

```
MEDNUM    medical record number
2
          Measurement Level: Nominal
          Column Width: 10  Alignment: Left
          Print Format: A10
          Write Format: A10

B32ACURR  B32,A, current
4
          Measurement Level: Scale
          Column Width: 8  Alignment: Right
          Print Format: F8
          Write Format: F8

B32AINIT  B32,A, initial
5
          Measurement Level: Scale
          Column Width: 8  Alignment: Right
          Print Format: F8
          Write Format: F8

B32BCURR  B32,B, current
6
          Measurement Level: Scale
          Column Width: 8  Alignment: Right
          Print Format: F8
          Write Format: F8
```

BASIS 32

```
B32BINIT  B32,B, initial
7
          Measurement Level: Scale
          Column Width: 8  Alignment: Right
          Print Format: F8
          Write Format: F8

B32CCURR  B32,C, current
8
          Measurement Level: Scale

          Column Width: 8  Alignment: Right
          Print Format: F8
          Write Format: F8
```

```
B32CINIT  B32,C, initial
9
          Measurement Level: Scale
          Column Width: 8  Alignment: Right
          Print Format: F8
          Write Format: F8


B32DCURR  B32,D, current
10
          Measurement Level: Scale
          Column Width: 8  Alignment: Right
          Print Format: F8
          Write Format: F8

B32DINIT  B32,D, initial
11
          Measurement Level: Scale
          Column Width: 8  Alignment: Right
          Print Format: F8
          Write Format: F8

B32ECURR  B32,E,current
12
          Measurement Level: Scale
          Column Width: 8  Alignment: Right
          Print Format: F8
          Write Format: F8
```

BASIS 32

```
B32EINIT  B32, E, initial
13
          Measurement Level: Scale
          Column Width: 8  Alignment: Right
          Print Format: F8
          Write Format: F8

DSM       Diagnosis
14
          Measurement Level: Nominal
          Column Width: 8  Alignment: Right
          Print Format: F8.2
          Write Format: F8.2

SA        Substance Abuse
15
```

```
          Measurement Level: Nominal
          Column Width: 15  Alignment: Left
          Print Format: A15
          Write Format: A15
```

Discharge Information

File Information

```
            List of variables on the working file

Name
Position

NAME      name of client
1
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Left
          Print Format: A20
          Write Format: A20

REFERRAL
4
          Measurement Level: Nominal
          Column Width: 16  Alignment: Left
          Print Format: A30
          Write Format: A30

CONTACT1
8
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: ADATE8
          Write Format: ADATE8

CONTACT2
9
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: ADATE8
          Write Format: ADATE8

LOS       Length of Stay
10
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
```

```
          Print Format: F8
          Write Format: F8
```

Discharge Information

```
REASON    reason for discharge
11
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

Value    Label

              1    completed program
              2    refused services
              3    receiving other services
            4    at large
              5    deceased
              6    moved
              7    other

DISCHARG
12
          Measurement Level: Nominal
          Column Width: 16  Alignment: Left
          Print Format: A30
          Write Format: A30

TRANSITI  did client make transition
16
          Measurement Level: Nominal
          Column Width: 15  Alignment: Right
          Print Format: F8.2
          Write Format: F8.2

          Value    Label

           1.00    yes
           2.00    no
           3.00    na

AXISONE
17
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
```

```
          Print Format: F8.2
          Write Format: F8.2
```

Discharge Information

```
AXISTWO
18
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: F8.2
          Write Format: F8.2

AGE
19
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8
SEX       sex
20
Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

          Value    Label

              1    male
              2    female
              3    other

RACE      race
21
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

          Value    Label

              1    white
              2    black
```

Discharge Information

```
EMPLOYME  employment status
22
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

          Value    Label

              1    employed
              2    part-time
              3    disabled
              4    unemployed

INSURANC  insurance status
23
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

          Value    Label

              1    medicaid
              2    medicare
              3    self-pay
              4    private

NEWAGE
24
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8.2
          Write Format: F8.2
```

Family and Significant Other Contacts

File Information

```
            List of variables on the working file

Name
Position
```

```
NAME      name of client
1
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Left
          Print Format: A20
          Write Format: A20

CONTACT   recommended family/so contact
4
          Measurement Level: Ordinal
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

          Value    Label

              1    staff
              2    client
              3    family/so
              4    other professional
              5    none

FORM      form of contact
5
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8
```

Family and Significant Other Contacts

```
        Value    Label

              1    f-t-f at COS
              2    phone message
              3    phone conversation
              4    letter
              5    f-t-f community
              6    other
              7    none


FREQUENC  contact with family
6
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: F8
```

```
          Write Format: F8

          Value    Label

              1    almost always
              2    regular,weekly
              3    sometimes, monthly
              4    sporadic, holidays
              5    almost never, once a year
              6    never
```

Elderly Hospitalization Rate

File Information

```
            List of variables on the working file

Name
Position

NAME      Name of client
1
          Measurement Level: Nominal
          Column Width: 20  Alignment: Left
          Print Format: A20
          Write Format: A20

AGE       age of client
4
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

HOSCURRE  Hospital stay, current
5
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

HOSPRIOR  Hospital stay, prior to COS
6
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8
```

Homeless Mental Health Access

File Information

```
            List of variables on the working file

Name
Position

NAME
1
          Measurement Level: Nominal
          Column Width: 15  Alignment: Left
          Print Format: A15
          Write Format: A15

TREATMEN  who requested services
3
          Measurement Level: Scale
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

          Value    Label

              1    Staff at day shelter
              2    Staff at night shelter
              3    CLIENT
              4    family or significant other
              5    Grady
              6    Georgia Regional
              7    Jail
              8    Community Professional
              9    Church

SERVICES  Services recieved
4
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Left
          Print Format: A8
          Write Format: A8
```

```
                    Value           Label

       a           therapy
       b           prescriptions
       c           referral
       d           medication
       e           vouchers
       f           assessment
       g           labs

APPOINTM  client returned for follow-up appointment
5
          Measurement Level: Nominal
          Column Width: 10  Alignment: Right
          Print Format: F8
          Write Format: F8

          Value    Label

              1    yes
              2    no

REFERRAL  client obtained referral services
6
          Measurement Level: Nominal
          Column Width: Unknown  Alignment: Right
          Print Format: F8
          Write Format: F8

          Value    Label

              1    yes
              2    no
```