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The Barriers Mentally Faces

Sandra Silvels

University of Tennessee at Chattanooga

BSW Social Work Program

Fall 2007-2008

BSW Social Work Program

SOCW 417

Valerie L. Radu, PhD. LCSW; Instructor

Anderson, A. J. (1997). Therapeutic program models for mentally ill chemical abusers. *International Journal of Psychosocial Rehabilitation*. 1(1). 21-33

This paper reviews the central issues in treatment strategies and program development for mentally ill chemical abusers (MICA patients). Patient treatment needs, historical context for divisions of service /system, treatment philosophies, and program model components are discussed in the context of treatment efficacy, program funding and community based treatment policies with regard to co morbidity. An integrated services approach, utilizing symptom and deficit reduction, within a combined holistic and disease specific program and an integrated program is provided. The potential benefits of treating MICA patients in integrated treatment programs are discussed.

Caton, C., Shrout, P., Eagle, P., Opler, L., and Dominquez, B. (1994). Risk factors for homelessness among schizophrenic men : a case-control study. *American Journal of Public Health Association*, vol. 84,265-270.

To Identify risk factors for homelessness among the severely mentally ill, we conducted a case-control study of 100 indigent schizophrenic men meeting criteria for literal homelessness and 100 such men with no homeless history. Subjects were recruited from shelter, clinic, and inpatient psychiatric programs in Upper Manhattan. Clinical interviewers employed standardized research instruments to probe three domains of risk factors: severity of mental illness, family background, and prior mental health service use. Homeless subjects showed significantly higher levels of positive symptoms, higher rates of a concurrent diagnosis of drug abuse, and higher rates of antisocial personality disorder. Homeless subjects experienced greater disorganization in family settings from birth to 18 years and less adequate current family support. Fewer homeless subjects than subjects in the never-homeless comparison group had a long-term therapist. These differences remained when demographic variables were adjusted statistically.

Culhane, D. P., Metraux, S., and Hadley, T. (2001). The impact of supportive housing for homeless people with severe mental illness on the utilization of the public health, corrections and emergency shelter systems: The New York –New York Initiative. *Fannie Mae Foundation.*

Data on 4,679 homeless people with severe mental disorders placed in supportive housing in New York city between 1989 and 1997 were merged with administrative data on the utilizations of public shelters, public hospitals, Medicaid-funded services, veterans inpatient services, state psychiatric inpatient services, state prisons, and the city's jails. A series of matched controls that were concurrently homeless but were not placed in housing were similarly tracked through administrative records.

Drake, R. E., Osher, F. C., and Wallach, M.C. (199). Homelessness and dual diagnosis. *American Psychological Association*, 46: 1149-1158.

People who are dually diagnosed with severe mental illness and substance use disorders constitute 10%-20% of homeless persons. They are a heterogeneous and extremely vulnerable subgroup with complex, poorly understood needs. In service needs of the dually diagnosed homeless population is reviewed. Also, the range of evolving approaches to providing social services, housing, and mental health and substance-abuse treatments; the relevant system issues and legal issues; and problems with current research, as well as future research directions, are discussed. The importance of the distinction between providing appropriate living environments and mental health treatments emerges throughout.

Drake, R. E., Wallach, M. A., & Hoffman, J.S. (1989). Housing instability and homelessness among aftercare patients of an urban state hospital. *American Psychiatric Association, 40:46-51.*

Homelessness as a dimensional concept reflecting instability of community living arrangements was examined in an urban state hospital's sample of 187 aftercare patients with chronic mental illness. According to ratings by outreach clinicians, 17 percent of the patients were predominantly homeless and 10 percent were occasionally homeless. Homelessness was strongly associated with abuse of alcohol and street drugs, treatment noncompliance, and a variety of psychosocial problems and psychiatric symptoms. Homeless patients wee viewed by their primary clinicians as attracted to the hospital as a living alternative and, during prospective one-year follow-up, had a much higher rate rehospitalization.

Gomez, D., Convey, M., Hilario, H., Corbett, A. M., & Weeks, M. (2007). Unofficial policy: access to housing, housing information and services among homeless drug users in Hartford, Connecticut. *Instituted for Community Research.*

Much research has shown that the homeless have higher rates of substance abuse problems, housing, and that substance abuse increases individual's vulnerability to homelessness. However, the effects of housing policies on drug users access to housing policies that affect drug user's access to housing. Qualitative interviews were conducted with 65 active users of heroin and cocaine at baseline, months. Participants were sampled to reflect a variety of housing statuses including homeless on the streets, in shelters, doubled-up with family or friends, or permanently houses subsidized, unsubsidized or supportive housing. Key informant interviews and two focus ground interviews were conducted with 15 housing caseworkers. Data were analyzed to explore the processes by which drug users receive information about different housing subsidies and welfare benefits, and their experiences in applying for these.

Handler, J., Doel, K., Henry, A., & Lucas, A. (2003). Rehab rounds: implementing supported Employment services in a real- world setting. *American Psychiatric Association,* 54: 960-962.

Supported employment is an evidence-based practice for people with serious mental illness (1). Among supported employment services, individual placement and support is a model whose efficacy has been convincingly demonstrated. To facilitate the transition from research to clinical practice, it is critical to understand how individual programs unfold in community mental health settings without the involvement of the academic creators of the model: can the program withstand the challenges encountered by real-world exigencies and still deliver the outcomes achieve in more controlled research? In this month's column, Dr. Handler and his colleagues describe the development of an individual placement and support program in Massachusetts, with particular emphasis on overcoming obstacles to implementation. They demonstrate that the path from research to practice can be traversed successfully with careful planning and foresight.

Lipton, F. R., Siegel, C., Hannigan, A., Samuels, J., & Baker, S. (2000). Tenure in supportive housing for homeless persons with severe mental illness. *American Psychiatric Association,* 51: 479-486.

The study examined the long-term effectiveness of approaches to housing homeless persons with serious mental illness. A total of 2,937 persons placed in high, moderate, and low-intensity housing were followed for up to five years. Intensity reflected on the amount of structure and degree of client's independence. The outcome variable was tenure in housing. Cox stepwise regression was used to calculate risk ratios of becoming discontinuously housed. Thirty percent of the sample was initially placed in high-intensity settings, 18 percent in moderate- intensity settings, and 52 percent in low-intensity settings. Those in high intensity settings tended to be younger, to be referred from hospitals, and to have a history or diagnosis of substance abuse. Individuals in moderate-intensity settings were more likely to be female and were least likely to have substance abuse problem. Individuals in low-intensity settings were more likely to be referred by municipal shelters and to have lived in municipal shelters four or more months. After one, two, and five years, 75 percent, 64 percent, and 50 percent, respectively, of the sample were continuously housed. Older age was associated with longer tenure, and from a state psychiatric center had a greater risk of shorter tenure. Individuals referred from a stat psychiatric center had a greater risk of shorter tenure than other types of referrals.

Miller, C. L., Drus, B. G., Dombrowski, M. A., & Rosenheck, R. A. (2003). Barriers to primary medical care among patients at a community mental health center. *American Psychiatric Association,* 54: 1158-1160.

People with chronic mental disorders may be at risk of reduced access to medical treatment and poor quality of medical care. The authors examined receipt of and barriers to medical treatment among patients at a community mental health center. Fifty- nine patients completed validate instrument for measuring access to medical care and the quality of primary care. Their responses indicated problems with access to care, and their scores were significantly lower than those of the general population on all four domains used to assess the quality of primary medical care. The findings suggest the need for community mental health centers to better address and address barriers to primary medical care.

Min, Y.S., Wong, Y. L., & Rothbard, A., B. (2004). Outcomes of shelter use among homeless persons with serious mental illness. *American Psychiatric Association*, 55: 284-289.

The purpose of this study was to examine the extent to which the use of case management services predicted public shelter use among homeless persons with serious mental illness after the termination of access to Community Care and Effective Services and Supports (ACCESS), a five-year outreach and case management program.

O'Connell, J., Mattison, S., Judge, C. M., Allen, H., & Koh, H. (2005). Public health approach to reducing morbidity and mortality among homeless people in boston. *Journal of Public Health Management & Practice,* 11 (4): 311-316.

Urban homeless populations suffer disproportionately high rates of premature death. In response to a wave of highly publicized deaths on the streets of Boston during the winter of 1998-1999, the Massachusetts Department of Public Health (MDPH) convened a task force to investigate these deaths and implement an integrated response to this public health crisis. Comprised of a broad coalition of public and private agencies as well as homeless persons and advocacy groups, monitored subsequent deaths among homeless persons in Boston, and implemented a comprehensive plan to address critical needs and prevent further multiple recent contacts with the medical, psychiatric, and substance abuse systems. In response to this finding, the MDPH Task Force sought to improve continuity of care and prevent future deaths among Boston's street population. Coordination of needed services was achieved through the creation of new, and often unconventional, partnerships. This case study exemplifies a public health practice response to the vexing health care challenges confronting homeless people who must struggle to survive on the streets and in shelters.

Rosenheck, R., Morrissey, J., Lam, J., Calloway, M., Stolar, M., Johnsen, M., Blasinsky, M., and Goldman, H. (2001). Service delivery and community: social capital, service systems integration, and outcomes among homeless persons with sever mental illness. *Health Services Research,* Vol. 36 (4).

This study evaluated the influence of features of community social environment service system integration on service use, housing, and clinical outcomes among homeless people with serious mental illness. STUDY SETTING: A one-year observational outcome study was conducted of homeless people with serious mental illness at 18 sites. Measurement of community social environment was based on local survey data. Service system integrate was assessed through interviews with key informants at each site to document inter-organization transactions. Standardized clinical measures were used to assess clinical and housing outcome face-to-face interviews. Structural equation modeling was used to determine the relationship between (1) characteristics of the social environment (social capital, housing affordability); (2) the level of integration of the service system for persons who are homeless in the community: (3) access to and use of services by individual clients; and (4) successful exit from homelessness or clinical improvement. Social capital was associated from a public housing agency and to a greater probability of exiting from homelessness at 12 months. Housing affordability also predicted exit from homelessness. Neither environment form systems integration predicted outcomes for psychiatric problems, substance abuse, employment, physical health, or income support. Community social capital and service system integration are related through a series of direct and indirect pathways with better housing but not with superior clinical outcomes for homeless people with mental illness.

Risenheck ,R. A., Mares, a. S., (2004). One – year follow-up of persons discharge from a locked intermediate care facility. *American Psychiatric Association,* 55: 56-64.

This study examined outcomes during a one-year follow-up for persons who were discharged from a locked intermediate care facility in an urban area in California. The purpose of this study was to determine the extent to which persons with severe mental illness can be successfully transferred from an intermediate care facility to lower levels of care.

Stefancic, A., and Tsemberis, S. (2007). Community- wide strategies for preventing homelessness: recent evidence. *The Journal of Primary Prevention.*

Housing first is an effective intervention that ends and prevents homelessness for individuals with severe mental illness and co-occurring addictions. By providing permanent, independent housing without prerequisites for sobriety and treatment, and by offering support services through consumer-driven Assertive Community Treatment teams, housing first removes some of the major obstacles to obtaining and maintaining housing for consumers who are chronically

homeless. In this study, consumers diagnosed with severe mental illness and who had the longest histories of shelter use in a usual control group. Participants assigned to housing, first were placed in permanent housing at higher rates than the treatment-as-usual group and over the course of four years, the majority of consumers placed by both Housing First must be aware of ways in which their practices may deviate from the essential features of Housing Firs, particularly with respect to enrolling eligible consumers on a first-come, first-served basis and separating clinical issues from tenant or housing responsibilities.

Uehara, E. S. (1994). Race, gender, and housing inequality: an exploration of the correlates of low-quality housing among clients diagnosed with severe and persistent mental illness. *Journal of Health and social Behavior*, Vol.35, p.309.

This paper explores the relationship of race and gender to housing quality among clients diagnosed with severe mental illness. More specifically, it asks: "How do a client's race and gender affect her/his odds of living in a "low-quality" housing arrangement?" a low-quality arrangement is defined as one which is time limited and/or physically unsafe. The analysis draws upon clinical, demographic, and housing data for 517 African American and white consumers of publicly-funded mental health services in King Country. Washington, Multivariate logistic regression is the primary analytic strategy used. Controlling for certain clinical/behavioral and economic/ecological factors, race/gender category is found to affect significantly the odds of experiencing low-quality housing.