Outreach teams use a range of strategies to engage people who are homeless and mentally ill and living on the streets. This chapter describes and evaluates the effectiveness of various voluntary and involuntary approaches and presents a new model program for serving this population.

A Perspective on Voluntary and Involuntary Outreach Services for the Homeless Mentally Ill

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In continuing efforts to address the public health concerns and reduce suffering of individuals who are homeless and mentally ill, New York City provides an array of services constituting a continuum of care that begins with outreach teams on the streets and ends with permanent supportive housing. In spite of the existence of these services, thousands of individuals with psychiatric disabilities are still on the streets. This chapter examines the clinical assumptions of the system, analyzes the barriers to services from the clients' perspective, reports on the effectiveness of involuntary psychiatric outreach interventions intended for clients who are uncooperative or in life-threatening situations, and offers an example of a model program for this population.

Homelessness: The Magnitude of the Problem

Homelessness remains an untreated epidemic in the United States. Since the first outbreak of the current episode during the 1980s, there has been a steady and dramatic increase in the number of people who experience homelessness. Because the definition of homelessness varies, there are many different ways of counting the homeless and it is impossible to get an accurate number at any one time. National estimates of the numbers of people who are homeless range from the U.S. Census Bureau's (1991) one-night count of 225,000 individuals

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The views expressed here are those of the authors and may not reflect those of the New York City Department of Mental Health, Mental Retardation and Alcoholism Services.

on the street and in the shelters, to the well-accepted estimate of 500,000 to 600,000 based on a seven-day count of the number of homeless individuals using shelters and soup kitchens across 178 cities (Burt and Cohen, 1989), to the 3 million estimated by advocates (Burt, 1996). In a study examining episodes of homelessness over a five-year period, an estimated 12 million adults in the United States were literally homeless at one time (Link and others, 1995).

In New York City, as in other major urban centers, the exact number of people who are homeless is difficult to ascertain. A comprehensive study of homelessness in New York City concluded that there are approximately sixty thousand to eighty thousand homeless individuals served by social service agencies during a given year and an additional thirty thousand homeless persons who are receiving few, if any, services (Barrow and others, 1991). A five-year longitudinal study of shelter use in New York City reported figures that are much higher than this one-year estimate. According to this study, an astounding 3.3 percent of the NYC population (330,000 people) had used the shelters and an unknown additional proportion were homeless on the streets (Culhane and others, 1994). The converging evidence indicates that the magnitude of current homelessness is much greater than even the advocates proclaim.

Furthermore, in the past twenty years in New York City, as well as nationally, there has been a severe reduction in the availability of affordable housing, thus increasing the number of people who are homeless. According to Lazere and others (1991), during this period, nationally, some 2.2 million low-rent housing units were removed from the real estate market, yet the number of low-income renters increased by 4.7 million. In New York City, 87 percent of low-income housing renting for less than $200 was lost from 1970 to 1982 (Koegel, Burnam, and Baumohl, 1996) due to gentrification. It is estimated that between 1970 and the mid-1980s over a million SRO units were demolished through the revitalization of the urban real estate market (Dolbeare, 1996).

Service Barriers for the Homeless Mentally Ill

The most fragile and vulnerable among the homeless are those diagnosed with mental illness or co-occurring psychiatric disabilities and substance use disorders. Estimates indicate that approximately one-third of the individuals who are homeless have severe mental illness (Dennis, Bruckner, Lipton, and Levine, 1991). Of the single adult homeless population, 25 percent to 37 percent either have a history of or exhibit serious mental disorders (Susser, Struening, and Conover, 1988), with 50 percent of these people having substance use disorders (Drake, Osher, and Wallach, 1991). Adding to their difficulties, people who are homeless suffer from acute and chronic physical ailments at an exceptionally elevated rate compared to domiciled populations (Wright, 1990). These co-morbidities complicate psychiatric conditions and create barriers to treatment.

There are many negative outcomes for individuals who are homeless with multiple disabilities—depression, frequent hospitalizations, suicidal behavior, dysfunctional family relationships (Osher and Drake, 1996), victimization (Hiday and others, 1999), and abuse (Goodman, Dutton, and Harris, 1995). In spite of the multiple needs of this population, studies have noted the extreme difficulty in engaging its members in traditional services (Asmussen and others, 1994; Cohen, Putnam, and Sullivan, 1984).

One of the main reasons that people in this group reject services is distrust and frustration with a mental health system that has proved inadequate or unwilling to meet their self-defined needs (Barrow and others, 1991). A second reason concerns the fragmentation of health, mental health, and substance abuse programs (Oakley and Dennis, 1996; Osher and Drake, 1996). Traditional mental health programs, including inpatient services, do not include treatment for substance use—and drug treatment programs are not equipped to cope with people with psychiatric disabilities. Many times treatment programs do not attempt to address housing options. Thus the system's inability to provide comprehensive services, including housing programs, results in those who are most vulnerable becoming the least likely to seek or obtain the help they need.

The Federal Task Force on Homelessness and Severe Mental Illness (U.S. Department of Health and Human Services, 1992) listed a range of services necessary for the successful integration and rehabilitation of individuals who are dually diagnosed. These services included assertive outreach, integrated case management, safe havens, housing, treatment of mental illness and substance abuse, health care, entitlements, vocational rehabilitation, family involvement, and legal protections. It was recommended that these services be provided within an integrated system of care.

New York City's Voluntary Outreach Services for the Homeless Mentally Ill

New York City has the largest homeless population and the greatest number of service providers for this population. Whereas there is broad diversity in demographic and clinical characteristics of people who are homeless and have psychiatric disabilities, the programs providing them with treatment and housing services are remarkable for their uniformity. The programmatic approach used by almost every provider is described as the continuum of care. The following section describes and evaluates the model.

The Linear Continuum of Care. New York City's service system for individuals who are homeless and mentally ill is consistent with the recommendations of the Federal Task Force on Homelessness and Severe Mental Illness and with the recommendations of the Way Home Coalition, a committee of providers, politicians, and advocates. The system consists of several hundred program components, which as a whole form a linear continuum of care designed to assist individuals who are homeless and mentally ill through a step-by-step progression of services that begins with outreach, includes treatment, and ends with permanent housing.

Outreach is the first step. The mission of outreach is to engage the individual who is literally homeless—living on the streets, in parks, transportation terminals, and other public places—and to encourage acceptance of a referral for the next service. The next step consists of a wide array of programs such as drop-in centers, shelters, and reception centers that allow the person to remain indoors, usually for a specified period of time, to obtain meals and a cot, and to take advantage of case management services offering assistance with entitlements as well as access to psychiatric or substance abuse problems. The purpose of these second-step programs is to develop clients' "housing readiness"—that is, to meet eligibility criteria of compliance with psychiatric treatment and periods of sobriety required by housing providers.

Housing, the most coveted and elusive good, is found at the third and final step. This step comprises a multi-tiered system that includes congregate residences, supportive SROs, supported housing, and independent housing. Most individuals are initially placed in an intensely supervised setting, that is, a group residence, from which they can gradually work their way toward their ultimate goal, independent housing. Moves along this housing continuum occur only if the resident complies with the psychiatric and substance abuse treatment and other requirements of the housing providers.

The System as Seen by Clients. From the client's perspective, this linear continuum model represents a series of hoops to jump through and the likelihood of success appears small. The client is first approached by an outreach team that works for weeks or months to establish a rudimentary relationship. When the outreach worker completes this "engagement period," the client is encouraged to move to the next step along the continuum—a drop-in center, shelter, treatment program, or transitional residence. The client is then introduced to a case manger who offers assistance with benefits, entitlements, and referrals to clinics or treatment programs, and eventually assists the client in moving to the next step. The journey from outreach to permanent housing takes many months—in some cases, years.

There are several other problems with the continuum model. It assumes that the skills a client needs for the future can be learned in an entirely different setting. However, the psychiatric rehabilitation literature indicates that the most effective way to teach a person the skills required for a particular setting is in that setting itself (Anthony and Blanch, 1989).

A second problem concerns the lack of choices for clients. Outreach generally begins with flexible, client-driven approaches, but at every subsequent step along the continuum, clients experience a loss of personal autonomy or choice in the process. To complete the process and qualify for housing, the client must meet with a psychiatrist, complete a period of sobriety, and agree to a housing placement determined by the clinical staff's assessment of his or her ability to function. Furthermore, the lack of control over life can push some individuals back to homelessness, as some prefer the relative independence of the streets to residential facilities (Howie the Harp, 1990).

A third problem is that providers require that individuals first treat their psychiatric and substance abuse problems prior to qualifying for housing. The system is based on the belief, widely held by clinicians, that for people who are homeless, treatment is an essential prerequisite for "housing readiness" (Rigway and Zipple, 1990). This perspective places clinicians' priorities above those of the clients. The value of treatment is compromised because clinicians use housing as leverage to increase adherence to a treatment plan that meets program requirements rather than to help clients realize their own goals (Susser and Roche, 1996). This approach is often used by clinicians with the rationale that compliance with the programs' requirements is likely to increase clients' ability to retain housing once it is finally obtained. From the clients' perspective, however, their most coveted and essential need is exploited for its value in increasing compliance with unwanted treatment.

A fourth problem concerns the demands the extant service system places on clients' social skills. Clients must repeatedly develop working relationships with new service providers and successfully meet program objectives in order to advance along in the continuum. The individuals this continuum is designed to serve often have profound deficits in social skills and negotiating these transitions is extremely difficult, especially without an advocate to provide continuity (Cohen and Tsemberis, 1991).

The counterpoint position to the linear continuum of care model, reported in several studies, is that homeless consumers perceive their need for services differently from the way providers do. Consumers place a higher value on meeting basic needs, especially housing, than on addressing mental health or substance abuse problems (Dattalo, 1990; Martin, 1990). Others see housing problems as relating less to disability and more to economic and social factors (Carling, 1993; Cohen and Thompson, 1992). These findings are consistent with results of surveys that show that consumers see lack of income, not mental disability, as their main barrier to stable housing (Tanzman, 1993).

Evaluating the Effectiveness of the Linear Continuum of Care Model. Two indicators can be used to evaluate the effectiveness of the linear continuum system. First, of the total number of people who receive outreach, how many obtain permanent housing? And, of those who attain permanent housing, what is the percentage who retain the housing? A recent report on service performance by a midtown NYC outreach team provides data that illustrates the difficulties in obtaining permanent housing (Sheffer, 1998). During a twenty-seven-month period, of the 156 clients that received regular outreach services, only 11 (7 percent) secured permanent housing.

The percentage of clients who retain housing was examined in a recent report issued by the Human Resources Administration (HRA), which administers the NY/NY Housing Programs for Homeless Mentally Ill Individuals. The majority of New York City's publicly funded housing programs for the homeless mentally ill, built under the NY/NY Agreement, use the linear residential continuum model. HRA recently completed a two-year study of housing retention rates across all NY/NY housing types of varying intensity of supervision. Over

the two-year period, the average retention rate for the entire sample (N = 3,558) was 59 percent. The retention rate for supported housing was 73 percent while the retention rate for individuals placed in MICA community residences was 36 percent (Lipton, 1997). These results indicate that a housing approach that allows clients more independence is more effective.

The Involuntary Outreach System

The involuntary outreach system consists of police activities and mental health statutes aimed at those individuals who are homeless, mentally ill, and unwilling or unable to participate in the mental health system. Involuntary initiatives require a determination that the person presents a danger to self or others.

Police Involvement. In recent years New York City has stepped up law enforcement efforts to reduce crime. Increased police activity and community policing tactics such as arresting individuals who commit small crimes in the event that they also are wanted for serious offenses have reduced the crime rate in New York City. But these strategies have had an adverse effect for those who are mentally ill since police are more likely to arrest the mentally ill than the non-mentally ill (Rock and Landsberg, 1996). Once arrested, people with mental illness are likely to be incarcerated for longer periods and have less access to alternatives to incarceration programs (Barr, 1999). This trend toward the incarceration of thousands of people with mental illness is taking place nationally (Lamb and Weinberger, 1998).

On any given day, there are an estimated 7,500 mentally ill inmates in New York State's jails and prisons. At least 2,800 of those are in the New York City jail system, making Rikers Island the largest inpatient psychiatric facility in the State (New York State Office of Mental Health, 1996). In 1997, approximately 33,000 prisoners in the New York City jail system required mental health services, and 15,000 were treated for serious mental disorders (Butterfield, 1998). In a study of homelessness among this population, Martell, Rosner, and Harmon (1995) reported that 43 percent of defendants with mental disorders were homeless at the time of the crime for which they were arrested. The vast majority of people with mental illness in the criminal justice system are not dangerous and are not incarcerated for long. Many are charged with relatively minor misdemeanors—the results of increased enforcement of "quality of life" crimes such as loitering, trespassing, jumping the turnstile, and so on. Discharge planning for treatment, let alone housing, if existent at all, is minimal and recidivism rates are extremely high. Finally, persons with a history of arrest are stigmatized twofold upon discharge—they are more likely to be arrested again and they are often considered ineligible tenants by housing programs.

Recent Developments in New York State Mental Hygiene Laws. State mental hygiene laws have been amended in the last five years to include a new statute that expands the authority of outreach teams to involuntarily transport a person who is mentally ill and presents a danger to self or others to a psychiatric emergency room for evaluation for admission. The new law (NY State Mental Hygiene Law—MHL 9.58) allows licensed mental health professionals including certified social workers, registered nurses, licensed psychologists, and physicians who are members of outreach teams to conduct a clinical evaluation and direct the local police to transport the person to an emergency room. This authority was previously only available to licensed psychiatrists under MHL 9.37. In the past five years, the total number of mental health professionals authorized to conduct involuntary transportation orders under Mental Hygiene Laws 9.37 and 9.58 increased from 21 to 153 (NYC Department of Mental Health, 1998).

The law also lowers the threshold for involuntary transport. The new law requires only that a person "*appears* to be mentally ill" compared to the earlier standard requiring that a person "*has a* mental illness for which immediate inpatient care and treatment in a mental hospital is appropriate."

One would expect that increasing the number of clinicians and lowering the standard for transport would increase the number of individuals who are involuntarily hospitalized. The data, however, do not support this prediction. The total number of cases of involuntary transportation (including cases reported by outreach teams and mobile crisis teams) reported to the NYC Department of Mental Health decreased from 362 cases in 1992 to 225 cases in 1997. The number of involuntary orders reported by Project HELP (Homeless Emergency Liaison Project), the City's emergency psychiatric team for individuals who are homeless and mentally ill, also reported a decline in involuntary hospitalizations over the last four years—from 298 cases in 1995 to 149 cases in 1998 (as reported in NYC Department of Mental Health, 1998).

There are several explanations for these counterintuitive findings. In earlier years (1992–1995), the authority for involuntary transportation of individuals who are homeless and mentally ill was located exclusively with one outreach team, Project HELP, which operates like a psychiatric emergency room on the streets (Tsemberis, Cohen, and Jones, 1993). All other outreach teams relied on Project HELP to enforce an involuntary transport order. It seems that granting the authority to impose involuntary transport to the neighborhood-based outreach teams increased the likelihood that clients of those teams would accept less restrictive services, thereby averting the need for involuntary transport. Furthermore, because neighborhood teams do not operate using the "psychiatric emergency room on the streets" model, they can establish relationships with clients and discuss or evaluate the need for involuntary transportation over a period of time. Contrary to expectations, implementation of the new mental hygiene law has resulted in effectively reducing the use of involuntary hospitalization, an intervention of last resort.

One of the major limitations with involuntary hospitalization is that even if the individual has a positive therapeutic experience while in the hospital, current discharge plans do not include careful planning for community housing; thus the person often returns to homelessness. An additional legislative initiative that would improve the effectiveness of involuntary commitment would be a mandate that holds hospitals accountable for the implementation of a discharge plan that includes housing.

New York City Involuntary Outpatient Commitment Pilot Program (MHL 9.61). The evaluation of a three-year pilot involuntary outpatient commitment program, operated by Bellevue Hospital, indicated that the quality of services received was more significant for patients' outcomes than was their legal status (voluntary or involuntary). Patients eligible for the program had a history of involuntary hospitalizations, were assessed to be incapable of surviving safely in the community without supervision, had a history of noncompliance with treatment, and were assessed to be likely to benefit from involuntary outpatient treatment. The eligible participants were randomly assigned to either involuntary outpatient commitment that included a court review or to a control group that offered the same services on a voluntary basis. Slightly more than 20 percent of the participants in the study were homeless. There were no significant differences between the experimental and control group in terms of rehospitalization, quality of life, symptomatology, or the number of clients who discontinued treatment. (For a complete report, see Policy Research Associates, 1998.)

In summary, in the best of circumstances involuntary interventions may offer otherwise unwilling individuals the opportunity to avail themselves of services. However, unless those services are comprehensive, of decent quality, and provide reasonable discharge plans that include housing, these individuals are unlikely to continue participating.

A Consumer Preference-Based Program Model: From Outreach to Permanent Housing

An innovative housing program for individuals who are street dwelling and mentally ill was developed by Pathways to Housing, a not-for-profit agency that recognizes that the first step in combating homelessness, regardless of coexisting conditions, is to provide individuals with housing (Tsemberis, 1999). In this program, housing is considered a basic human right, not a commodity to be earned on the basis of sanctioned behaviors or some predetermined set of conditions that the individual must meet but based simply on need. At the point of engagement, clients are offered immediate access to permanent independent housing. Once housed, the client receives intensive treatment and support services from an Assertive Community Treatment team. Clients are offered physical health, mental health, and substance abuse treatment, vocational rehabilitation, and assistance with community and social integration. All these services are provided by the same team from the same agency, thus providing continuity of care for the client. By providing clients with immediate access to apartments of their own, the Pathways team develops a powerful bond with each client—who is then likely to accept many other needed treatment services from them. In its five-year history, the Pathways "streets to homes" program has housed more than 250 individuals. Approximately 65 percent of the clients engaged by outreach attain independent permanent housing within a six-month period and the overall housing retention rate for this program is 85 percent (Tsemberis, 1999).

Conclusion

Outreach is the first step. Successful outreach teams are flexible, tolerant, persistent, and highly creative in their use of engagement strategies. Regardless of any team's success in engaging a client, the policies of the linear continuum of care system often stymie the team's ability to achieve its ultimate goal—to secure housing. The recent expansion of laws to improve the "quality of life" only led to an increase in the number of arrests of people who are homeless and mentally ill, which ultimately served to shift the onus of responsibility for treatment of this population to the woefully inadequate criminal justice system. Expanding the mental health laws may increase the effectiveness of outreach teams, but companion legislation is needed to address inefficiencies in the discharge process and to ensure that housing is part of the plan. Outreach can be more than just a first step when the outreach effort also offers immediate access to permanent housing and other necessary services; it can then be a transforming step in the individual's search for a better way to live.

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