A TREATMENT IMPROVEMENT PROTOCOL

Behavioral Health Services for People Who Are Homeless

TIP 55

Substance Abuse and Mental Health Services Administration
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TIP 55

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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Acknowledgments

This publication was produced under contract number 270-09-0307 by the Knowledge Application Program (KAP), a Joint Venture of The CDM Group, Inc., and JBS International, Inc., for the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Christina Currier served as the Contracting Officer's Representative.

Disclaimer

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Recommended Citation

Substance Abuse and Mental Health Services Administration. *Behavioral Health Services for People Who Are Homeless.* Treatment Improvement Protocol (TIP) Series 55. HHS Publication No. (SMA) 13-4734. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

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HHS Publication No. (SMA) 13-4734
First Printed 2013

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). Each TIP involves the development of topic-specific best-practice guidelines for the prevention and treatment of substance use and mental disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts in various forms of treatment and prevention. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://kap.samhsa.gov.

Although each consensus-based TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that behavioral health is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. If research supports a particular approach, citations are provided.

Foreword

The Treatment Improvement Protocol (TIP) series fulfills the Substance Abuse and Mental Health Services Administration's (SAMHSA's) mission to improve prevention and treatment of substance use and mental disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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How This TIP Is Organized

This Treatment Improvement Protocol (TIP) is divided into three parts:

- Part 1: *A Practical Guide for the Provision of Behavioral Health Services*
- Part 2: *An Implementation Guide for Behavioral Health Program Administrators*
- Part 3: *A Review of the Literature*

Part 1 is for behavioral health service providers and consists of two chapters. Chapter 1 illustrates typical problems and issues that arise in behavioral health counseling with people who have experienced or currently are experiencing homelessness. It covers:

- Approaches that address the counselor's setting, role, and responsibilities.
- Screening/assessment, client-centered treatment planning, treatment processes, and continuing care.

Part 1, Chapter 2, presents seven vignettes; each describes the setting in which the counselor is providing services, step-by-step instructions for specific counseling techniques, and master clinician comments. A decision tree is also included in the Francis vignette to help counselors manage key points of therapy. The techniques can be applied to and adapted for other settings. Vignettes are based on role-played interactions staged by consensus panelists.

Part 2 is for program administrators and consists of two chapters addressing the following topics about servicing people who are homeless:

- Collaboration with other service providers to provide comprehensive services
- Service modifications to meet the individual needs of clients
- Providing training and staffing programs that serve people who are homeless
- Providing outreach and engagement, intensive care, and ongoing rehabilitation services
- Resources for implementation of best practices, including sample policies and procedures

Part 3 is a literature review on the topic of homelessness and behavioral health services and is intended for use by clinical supervisors, interested providers, and administrators. Part 3 has three sections: an analysis of the literature, links to select abstracts of the references most central to the topic, and a general bibliography of the available literature. To facilitate ongoing updates (performed periodically for up to 3 years from first publication), the literature review is only available online at the Knowledge Application Program Web site (http://kap.samhsa.gov).

Terminology

Substance abuse: Throughout the TIP, the term "substance abuse" has been used to refer to both substance abuse and substance dependence (as defined by the *Diagnostic and Statistical Manual of Mental Disorders,* 4th Edition, Text Revision [DSM-IV-TR] [American Psychiatric Association, 2000]). This term was chosen partly because substance abuse treatment professionals commonly use the term "substance abuse" to describe any excessive use of addictive substances. In this TIP, the term refers to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine what possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders described by DSM-IV-TR.

Behavioral health: Throughout the TIP, the term "behavioral health" is used. Behavioral health refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illness and substance use disorders, which are often chronic in nature but from which people can and do recover. The term is also used in this TIP to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use and related problems, treatments and services for mental and substance use disorders, and recovery support. Because behavioral health conditions, taken together, are the leading causes of disability burden in North America, efforts to improve their prevention and treatment will benefit society as a whole. Efforts to reduce the impact of mental and substance use disorders on communities in the United States, such as those described in this TIP, will help achieve nationwide improvements in health.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Major dimensions that support a life in recovery, as defined by the Substance Abuse and Mental Health Services Administration, include:

- ***Health:*** overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way.
- ***Home:*** a stable and safe place to live.
- ***Purpose:*** meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society.
- ***Community:*** relationships and social networks that provide support, friendship, love, and hope.

Part 1: A Practical Guide for the Provision of Behavioral Health Services

Part 1, Chapter 1

IN THIS CHAPTER

- Introduction
- Homelessness in America
- Homelessness and Behavioral Health Services
- Stages of Change, Recovery, and Rehabilitation
- Clinical Interventions and Strategies for Serving People Who Are Homeless
- Special Issues in Service Delivery
- Community Housing Services for People Who Are Homeless
- You Can Do It

Introduction

This TIP Is for You, the Behavioral Health Service Provider

This Treatment Improvement Protocol (TIP) is for you, the behavioral health service provider or program administrator who wants to work more effectively with people who are homeless or at risk of homelessness and who need, or are currently in, substance abuse or mental health treatment. The TIP addresses treatment and prevention issues. Some aspects of the TIP will be of primary interest to counselors across settings, whereas others will be of primary interest to prevention professionals or providers in primary care settings. However, the approach advocated by the TIP is *integrated* and is aimed at providing services to the whole person to improve quality of life in all relevant domains.

The information in this TIP can be useful to you if you wish to:

- Be a more effective clinician for people facing potential or actual homelessness.
- Recognize and address homelessness as a special dynamic that affects your clients.
- Help prevent potential crises that result from becoming homeless.
- Provide preventive services for individuals and families who are homeless, especially as they relate to emergent substance abuse or mental disorders.
- Be more aware of the effects of psychological trauma and co-occurring disorders (CODs) among people who are homeless.
- Provide integrated, more effective services to people who are homeless.
- Understand and know how to utilize resources for homelessness (e.g., permanent supportive housing [PSH]) in your community.

- Understand the significance of cultural competence in your work with people who are homeless and experience substance use and mental disorders.
- Influence the understanding of others in your community regarding the interrelationship of homelessness, substance abuse, and mental illness.

Behavioral health service providers work today in a variety of settings: publicly funded treatment programs, primary care organizations, hospitals, criminal justice settings, private practice, the military, schools, the community, and programs specifically for people who are homeless. You will find the information in this TIP useful regardless of the setting in which you work. Although some content may be more relevant to your work than other content, it is important to have an overall view of how homelessness, substance abuse, and mental illness interact to hinder recovery and rehabilitation; how to form a conceptual model to address homelessness in your work; and how to access services available in your community.

This chapter introduces you to homelessness in America. It illustrates how homelessness affects people, why it often occurs in conjunction with other social and health problems, and why it cannot be addressed in isolation. It also provides a brief overview of how communities address homelessness and discusses different types of homelessness and how each interacts with substance use and mental disorders.

In addition, the chapter discusses your role(s) as a provider in working with this population. Some of the topics addressed include:

- The special competencies you will need in your work with people who are homeless.
- Knowledge, skills, and attitudes in working with specialized community resources that can support treatment and prevention for people who are homeless.
- How to build responses for homelessness or the threat of homelessness into individualized service or treatment plans.
- How to adapt services to the changing needs of people who are homeless as their life situations change.
- How to help individuals without permanent housing integrate with other people in behavioral health service settings.
- The types of preventive services people who are homeless may need.
- Provider self-care when working with the problems of homelessness.

The chapter closes with a discussion of how communities can address homelessness and acquaints you with services that may be available in your community for people who are experiencing or who may be at risk for the overwhelming problem of homelessness. Many resources already exist, and it is important for you as a behavioral health service provider to understand and actively interact with existing organizations to provide integrated, continuous, and nonduplicative service to clients who are homeless.

Structure of the TIP

This TIP has three parts:

- Part 1: *A Practical Guide for the Provision of Behavioral Health Services*
- Part 2: *An Implementation Guide for Behavioral Health Program Administrators*
- Part 3: *A Review of the Literature*

Part 1 is for behavioral health service providers and consists of two chapters. In addition to background information, Chapter 1 illustrates common issues that arise in working with people who have experienced, are currently experiencing, or may be at risk for homelessness. It covers:

- Background issues, such as the nature and extent of homelessness among clients in treatment, descriptions of models, and

principles of care that anchor the practical information the TIP presents.
- The service provider's roles, competencies, and self-care.
- Outreach, assessment, treatment planning, the treatment process, and continuing care.
- Preventive services for people who are homeless.

Part 1, Chapter 2, presents a series of vignettes that serve as teaching tools. Treatment vignettes describe the setting in which a worker provides services, step-by-step instructions for specific clinical techniques, and master clinician comments. Vignettes that incorporate prevention interventions describe situations in which a behavioral health service provider assesses prevention needs and either provides services or refers to a community agency. Some vignettes provide decision trees to help behavioral health service providers manage key points of service delivery. Most of the vignettes are based on role-plays conducted by the TIP consensus panelists.

Part 2 is for program administrators and consists of two chapters. Chapter 1 deals with providing programming tailored to the needs of people who are homeless, including:
- Tailoring services to the needs of the population.
- Providing training and staffing to serve people who are homeless.
- Providing outreach and engagement, intensive care, and ongoing rehabilitation services.

Part 2, Chapter 2, contains sample policies and procedures that support effective services and collaboration with other service providers to offer comprehensive services for people who are homeless, along with sample forms and lists of steps for program modification.

Part 3 has three sections: a review of the literature on the prevention and treatment of substance abuse and/or mental illness among individuals who are homeless, links to select abstracts of the references most central to the topic, and a general bibliography of available literature. To facilitate ongoing updates (performed periodically for up to 3 years from first publication), the literature review is only available online at the Knowledge Application Program Web site (http://kap.samhsa.gov).

Topics Addressed in This TIP

This TIP covers a broad range of skills and resources useful in work with people experiencing homelessness or at significant risk for homelessness. For instance, the TIP addresses different types of homelessness: transitional, episodic, and chronic. It provides information on different resources and services for people who lack adequate housing, including emergency, temporary, transitional supportive, and permanent supportive housing resources. It describes a variety of strategies that are instrumental in services to people who are homeless, including outreach, initial screening and evaluation, early intervention and stabilization, coordination with other resources in the community, treatment planning, case management, client retention in treatment and rehabilitation, and relapse prevention and recovery management. It also sensitizes clinicians to the special effects of psychological trauma, both as a precursor and a contributing factor to homelessness and as a secondary outcome of homelessness. The TIP considers the effects of co-occurring disorders as a causative factor of homelessness and the special needs of clients who are homeless and have co-occurring substance use and mental disorders.

The TIP considers stages of homelessness rehabilitation, including outreach and engagement, transition to intensive care, intensive care, transition to ongoing rehabilitation, and

rehabilitation. It covers a variety of evidence-based practices for both prevention and treatment. Part 2 of the TIP considers major funding resources, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Veterans Affairs (VA), and other governmental resources; staffing; and other information of benefit to administrators.

The TIP is comprehensive in scope and provides the detail that counselors, preventionists, and other professional staff need to provide services in a variety of contexts to clients with a variety of needs. The TIP describes intervention methods that can be used in a variety of stages of homelessness rehabilitation and methods for pursuing recovery from mental illness and substance abuse among people and families who are homeless. It addresses the importance of the integration of behavioral health services with other social services and health care. The TIP recognizes the complexity of providing services to clients who are in stressful life situations and may resist or misinterpret the efforts of service providers. Perhaps most importantly, the TIP emphasizes the need for behavioral health systems to address the needs of the whole person, including not only mental health issues and substance use, but housing, safety, physical health, financial, vocational, family, interpersonal, and other life contexts.

Additionally, this TIP considers content from SAMHSA's Strategic Initiatives (SIs), which are delineated in the document entitled *Leading Change: A Plan for SAMHSA's Roles and Actions 2011-2014* (SAMHSA, 2011b). The specific SIs addressed include:

- **Prevention of substance abuse and mental illness** (SI #1) by creating safe places for people to live accompanied by mental health and substance abuse screening and supportive treatment.
- Reducing the potential for and effects of violence and **trauma** (SI #2) by providing safe environments and by recognizing trauma symptoms and providing trauma-informed services.
- The provision of homelessness services to **military families** (SI #3) and veterans, which includes recognizing their special needs and the importance of coordinating their care with the VA.
- Utilizing **recovery supports** (SI #4) provided by people in recovery from mental illness and substance abuse in the community to support individuals and families who are homeless.
- Creating **public awareness and support** (SI #8) for people who are homeless and have mental illness and/or substance use disorders.

Did You Know?

- There is no typical profile for persons experiencing homelessness. A person who is homeless may be, for example:
  - Someone who has lost his or her job or experienced mortgage foreclosure and has been evicted along with family members.
  - A loner who sleeps in the park in a sleeping bag.
  - An individual leaving jail or prison who has an untreated drug problem and no place to live.
  - A runaway teen who trades sex for food and drugs.
  - A person in early recovery without enough money to pay the rent.
  - A person with serious mental illness (SMI) who needs long-term permanent supportive housing.

  - A person kicked out of the family home due to problems accompanying substance abuse.
- More than 1 in 10 persons seeking substance abuse or mental health treatment in the public health system in the United States is homeless (SAMHSA, Office of Applied Studies [OAS], 2006).
- Keeping things together while being homeless takes considerable skill and resourcefulness. People who are homeless often have well-developed street skills, resourcefulness, and knowledge of the service system—important strengths that can be built upon in treatment.
- People who are homeless, particularly those with co-occurring mental and substance use disorders, present particular challenges in treatment. All issues must be concurrently addressed for treatment to be effective.
- People with substance use or mental disorders who are homeless are more likely to have immediate life-threatening health conditions and to live in life-threatening situations. The first steps toward healing may be access to medical care and a safe and healthy place to live.
- Trauma is another major co-occurring problem for people who are homeless and have a substance use disorder. One study found that about one fifth of men and one third of women who are chronically homeless and have substance use disorders also have posttraumatic stress disorder (PTSD; Jainchill, Hawke, & Yagelka, 2000).
- Safe housing is a point of entry into treatment for many individuals. When safe housing is combined with services, the client has the opportunity to build strengths to move from the precontemplation stage through the contemplation stage to an active stage of change concerning recovery from mental illness and substance abuse.
- Many individuals in early recovery are only a paycheck away from homelessness.
- People leaving prison or jail with no place to live who have an untreated substance use or mental disorder may lack familial, occupational, and social resources and supports.
- People who have experienced multiple episodes of homelessness or who have been chronically homeless may be especially demoralized and depressed. In addition, in prior contacts with service systems, these individuals may have experienced alienation that will require behavioral health service providers to exercise a full battery of professional engagement and customer service skills.

Why Address Homelessness in Substance Abuse and Mental Health Programs?

Serving people who are homeless in behavioral health agencies is challenging. So, why do it?

- It is crucial. Housing instability is common among people diagnosed with substance use or mental disorders. This instability may take the form of:
  - Risk of eviction and/or estrangement from families.
  - Risk of homelessness after a stay in jail, prison, or residential treatment.
  - An inability to maintain adequate housing over a period of time.
- Housing stability is key for long-term recovery from substance use and mental disorders; providing housing with treatment and other services reduces relapse (Kertesz, Horton, Friedmann, Saitz, & Samet, 2003) and improves outcomes (Milby et al., 2008; Sosin, Bruni, & Reidy, 1995).
- It is good for your organization. Addressing the root causes of crises caused by homelessness results in better client retention,

efficient organizational functioning, and greater program service diversity.
- Participation in your community's continuum of care for homeless assistance services fosters professional relationships, funding opportunities, innovative programming, and access to a broader range of services for the people you are serving.
- It is good for your community. As communities develop plans to end homelessness, increased funding and resources become available to implement programs and coordinate services. Programs are able to target and respond to specific community needs more efficiently and effectively, and some of the problems intensified by homelessness—such as aggressive panhandling—are reduced.

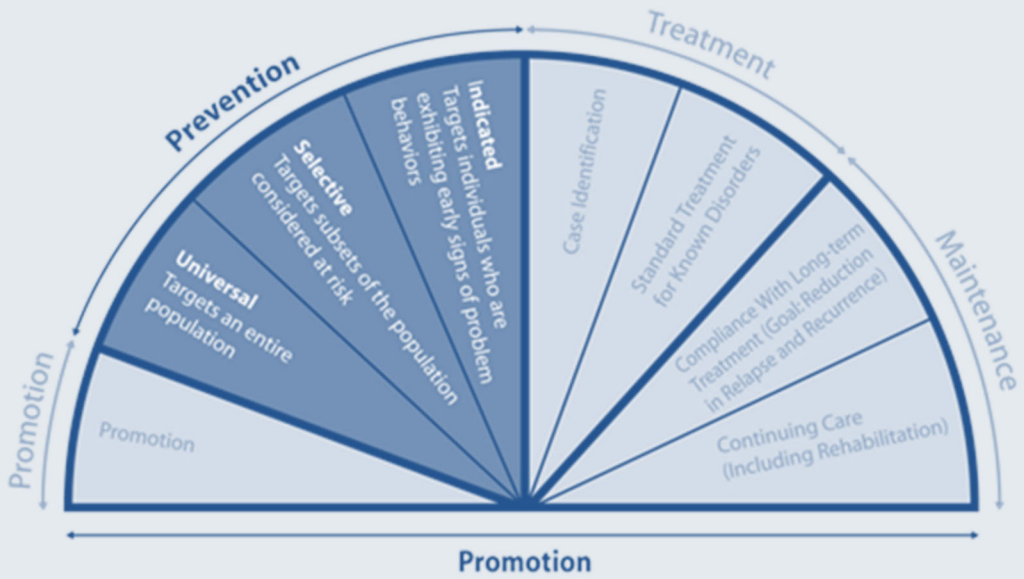
Preventive Services for People Who Are Homeless

People who are homeless are at elevated risk for substance abuse, mental disorders, and various other physical ailments and social problems (e.g., unemployment, poverty, victimization). Preventive services can reduce these risks before problems occur or when early signs of the problem are evident. As shown in Exhibit 1-1, the Institute of Medicine (IOM; 2009) divides substance abuse and mental health services into four broad categories: promotion, prevention, treatment, and maintenance. Prevention services are further divided into:

- Universal prevention services, which target entire populations (i.e., a community, State, or country).
- Selective prevention services, which target subsets of the population considered to be at risk.
- Indicated prevention services, which are delivered to individuals and target people who are exhibiting early signs of problem behaviors.

By definition, universal prevention efforts are not specifically targeted to persons who are homeless because they are part of a larger community, State, or national population.

Exhibit 1-1: Types of Prevention as Described by the Institute of Medicine



Source: IOM, 2009. Adapted with permission.

However, people who are homeless may be the beneficiaries of these prevention efforts (e.g., workplace programs, recreation programs, enforcement efforts to reduce crime, school-based prevention programs for children enrolled in school). Because of their high-risk status, these efforts may be especially important to persons who are homeless or at risk of becoming homeless.

This TIP focuses primarily on selective and indicated prevention, referring to them collectively as "clinical preventive services," as they are often provided in clinical settings (primary care, hospitals, counseling centers, etc.). Clinical preventive services include life skills development, stress and anger management, anticipatory guidance, parenting programs, and screening and early intervention. These programs may be designed to directly prevent substance abuse and/or promote mental health and may strengthen individuals and families and enrich quality of life to build resiliency.

The categories in Exhibit 1-1 are tools for considering prevention initiatives; they aren't hard and fast. In practice, they often blend, and a given initiative may fit into more than one category.

Housing as prevention

Providing housing to people who are homeless can help prevent the exacerbation of substance use and mental disorders or the transition from normal functioning to the first phases of problem development. A number of considerations support this assertion.

Homelessness itself is a risk factor for mental and substance use disorders, given the many life challenges and disruptions that people who are homeless face: for example, stress, loss of social connectivity, increased threats, harm through victimization and exposure, and deterioration of health status. Indeed, these risk factors for adults and youth are one reason this TIP emphasizes the importance of preventive services for people who are homeless.

Effects may be especially acute in children, for whom homelessness may mean a loss of family stability, disruptions in school attendance or performance, and being ostracized by peers. Brokering prevention services in the community can help mitigate the impact of these circumstances (see the "Case Management" section later in this chapter as well as Vignettes 4 and 6 in Part 1, Chapter 2).

Are you a prevention worker in the behavioral health field?

When many professionals think of prevention service providers, mental health and substance abuse workers come to mind. In truth, a broad array of professionals in the community contributes to the treatment and prevention of mental illness and substance abuse. The community agencies and organizations listed in Exhibit 1-2 have a part to play in the prevention of these problems. If your agency or organization is on this list, you are a prevention worker.

Not only does your community benefit when professionals from a wide range of sectors participate in prevention; you may also find your job to be easier as well. People with substance use or mental disorders often present significant treatment challenges in the community agencies and organizations with which they have contact. When substance abuse and mental health issues are prevented or identified early, quality of life improves for everyone.

It is beyond the scope of this TIP to provide an introduction to prevention theory and practice. Instead, it focuses on preventive services for persons who are homeless.

Exhibit 1-2: Agencies That Provide Substance Abuse Prevention and Mental Health Promotion Services

State Governments
Public health authority
Substance abuse authority
Mental health authority
Governor's Highway Traffic Safety Office
Alcohol beverage control
State aging and disability authority
State police
Corrections

County/Local Governments
Public health authority
Substance abuse authority
Mental health authority
Tribal governments
Courts/probation
Local police
Recreation departments
Area agencies on aging

Educational Institutions
K–12 schools
Colleges, universities
Research centers

Healthcare Facilities
Primary care
Specialty care (e.g., mental health/substance abuse, emergency/trauma, obstetrics and gynecology, home health, dentistry)

Nongovernmental Organizations
Community coalitions
Boys/Girls Clubs, Young Men's/Women's Christian Association (YMCA/YWCA), Scouts
Fraternal organizations
Faith-based organizations
Hospitality industry
Housing and homelessness service organizations

Media Outlets
Print
Electronic
Billboards, bus placards, etc.

Recommendations of the Consensus Panel

You are a behavioral health professional working with people who are homeless or at risk for homelessness, but most likely, your background does not include detailed training in addressing this aspect of their lives. This TIP is designed to fill that gap and increase your understanding of how homelessness affects a person's ability to engage in treatment or benefit from prevention. In particular, the consensus panel recommends the following:

- Housing access is the bulwark of recovery for a person who is homeless and has a substance use disorder and/or a mental illness. Various housing models can be effective in addressing homelessness and substance abuse or mental illness. You must be active in identifying housing resources as you assess and work with abstinence readiness in your clients.
- Solving homelessness is more than just having a safe place to live. Homelessness typically presents along with multiple, complex other problems: substance abuse, mental health issues, medical problems, legal/criminal justice issues, social challenges, and so forth. You must be able to prioritize these factors when creating a person-centered treatment or prevention plan and know how to access appropriate supervision concerning these complexities.
- People who experience homelessness can be particularly demoralized, needing active and often persistent engagement; be flexible in engaging them, especially in earlier stages of work.
- Income stability through access to Federal or local income benefits is a critical ingredient in helping a person who is homeless

reintegrate into the social mainstream. Clinicians and prevention workers must know how to help the people they serve gain access to these benefits.

- Work and/or education are basic goals for the majority of people who are homeless. These are sources of significant self-esteem, counteracting demoralization and providing daily structure and a long-term foundation to prevent subsequent homelessness. You will want to be familiar with community resources for vocational and educational training and placement.
- Many people who are homeless have no social supports, but some do—especially those with brief intermittent periods of homelessness. Family or close friends can offer support; be alert to these resources when helping people repair their social networks. For someone with a history of chronic homelessness, you may need to re-conceptualize how to help rebuild his or her social supports.
- People who experience homelessness encounter a range of problems. You can apply the skills gained from serving this population to your work with anyone experiencing biopsychosocial challenges. Conversely, the techniques you have already mastered can be applied in your work with people who are homeless, depending on the stage of change they are in.

Homelessness in America

How Is Homelessness Defined?

There is no single definition of homelessness; however, most Federal homelessness programs use the definition of a homeless individual provided by the McKinney-Vento Act (P.L. 100-77):

> An individual who lacks a fixed, regular, and adequate nighttime residence; and a person who has a nighttime residence that is (a) 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, nor ordinarily used as, a regular sleeping accommodation for human beings. (42 U.S.C. § 11302)

In other words, a person experiencing homelessness has no fixed place to live and often dwells in public spaces, shelters, or drop-in centers or may double up in others' homes in a temporary or makeshift way. The more recent Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 (P.L. 111-22), which amends the McKinney-Vento Act (see Part 2, Chapter 1, for further detail), expands the definition (Sec 103, 42 U.S.C. § 11302) of a person or family who is homeless to include anyone who:

- Resided in a shelter or place not intended as a home and is now leaving an institution where he or she temporarily resided.
- Is losing his or her housing in 14 days or fewer; cannot obtain housing through his or her support networks or other resources.
- Has, at some point, lacked independent permanent housing for a long period of time; has moved frequently; and is likely to continue doing so as a result of physical disability, mental disorder, addiction, or other barrier.
- Has experienced domestic violence, sexual assault, and/or other dangerous or life-threatening conditions in a housing situation that he or she is leaving.
- Is an unaccompanied youth who is homeless.

HUD (2001) defines a person who is chronically homeless as "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four [4] episodes

of homelessness in the past three [3] years" (p. 6). Unaccompanied individuals who are homeless are men and women not accompanied by children or a partner. Disabling conditions include mental disorders, substance use disorders, and medical conditions.

How Many People Are Homeless?

It is difficult to count the number of people who are homeless accurately because they move frequently. This means they can be counted more than once or missed. HUD has estimated, based on point-in-time counts, that 643,067 persons were homeless at a single point in time in January 2009, of whom 237,934 were on the streets, in abandoned buildings, or in other places not meant for human habitation (HUD, 2010). Sixty-three percent of people who were homeless were single individuals and the rest were members of families experiencing homelessness. Another estimate using these data arrived at a slightly higher number: 656,129, a 3 percent increase over the previous year. The number of families facing homelessness increased by 4 percent over the same period, although the figures are much higher in some States (Sermons & Witte, 2011). The full extent of the effects of the 2008 recession on homelessness may not be measured for some time.

On a single night in 2009, an estimated 75,609 veterans were homeless; 57 percent were staying in an emergency shelter or transitional housing program, and the remaining 43 percent were unsheltered—that is, living on the street, in an abandoned building, or in another place not meant to serve as a human dwelling. Of veterans in shelters, approximately 96 percent were individuals and slightly less than 4 percent were part of a family that was homeless (HUD & VA, 2010). For more information, see the online literature review in Part 3 of this TIP.

Who Is Homeless?

People who are homeless come from all strata of society, although the poor are most certainly overrepresented. The high percentage of people of color in the homeless population is related to their chances of being poor, not to their race/ethnicity (Burt, 2001). The National Survey of Homeless Assistance Providers and Clients (Burt et al., 1999) reported that:

- About 40 percent of clients who are homeless are African American, about 40 percent are White, about 11 percent are Hispanic, and about 8 percent are Native American.
- About 61 percent of clients are men by themselves, 15 percent are women by themselves, 15 percent live with their own children under age 15, and 9 percent live with another adult.
- Clients who are homeless are concentrated in central cities (71 percent), with fewer in urban fringe areas and suburban areas (21 percent) and rural areas (9 percent).

What Factors Contribute to Homelessness?

Both the environment and individual factors contribute to homelessness.

Environmental factors

Poverty predisposes people to homelessness through a range of environmental factors; 5 to 10 percent of people who are poor experience homelessness in a given year (Burt, 2001). Since the 1970s, vulnerability to homelessness has increased among the poor as access to affordable housing, social safety nets (e.g., housing/income subsidies, affordable health care, hospitalization), and adequate income have decreased. In addition:

- Housing costs price many people with below-poverty incomes (e.g., very low-income families and single adults) out of the market (Burt, 2001). More than 14

million families have "worst-case housing needs," defined as spending more than 50 percent of monthly income on rent (Lipman, 2002).

- The removal of institutional supports (e.g., deinstitutionalization) has resulted in fewer housing options for people diagnosed with SMI (Burt, 2001). It is critical that housing issues be addressed in disposition planning when individuals are discharged from inpatient or outpatient mental health or substance abuse treatment settings. Clients leaving intensive treatment settings who do not have adequate housing to support their recovery have a significantly higher risk of relapse.
- Decreased job options for people with high school educations and increasing disparity between minimum wage and cost of living have made it increasingly difficult to earn enough money to afford housing (Burt, 2001).

Environmental factors affecting vulnerability to homelessness relate directly to community resources. Community solutions for preventing homelessness and ending chronic homelessness include affordable housing, access to permanent supportive housing for clients with mental illness and substance use disorders, improved schools, training, prison transition programs, job opportunities, and support services (Burt, 2001).

Individual factors

In addition to substance use and mental disorders, a range of complex, interrelated individual risk factors are related to homelessness, including trauma-related symptoms, cognitive impairment, medical conditions, lack of support from family, limited education and job skills, and incarceration (for more detail, see the literature review in Part 3 of this TIP, which is available online at the KAP Web site (http://kap.samhsa.gov). A significant percentage of individuals who are homeless will likely experience at least one of these issues. For example:

- Mares and Rosenheck (2004) found that veterans who are homeless report that three aspects of their service contributed to their homelessness: substance abuse beginning in the military (75 percent), inadequate preparation for civilian employment (68 percent), and loss of structure (68 percent).
- People who have or have had mood disorders, schizophrenia, antisocial personality disorder, or any substance use disorder are at least two times more likely to have been homeless than those without these diagnoses (Greenberg & Rosenheck, 2010a,b).
- Of people who are homeless and in substance abuse treatment, 68 percent of men and 76 to 100 percent of women report trauma-related events (Christensen et al., 2005; Jainchill et al., 2000), similar to rates reported by general samples of people who are homeless.
- As many as 80 percent of people who are homeless exhibit cognitive impairment, which can affect their social and adaptive functioning and their ability to learn new information and new skills (Spence, Stevens, & Parks, 2004).
- People who are homeless have high rates of HIV/AIDS, hepatitis C, cardiovascular conditions, dental problems, asthma, diabetes, and other medical problems (Klinkenberg et al., 2003; Magura, Nwakeze, Rosenblum, & Joseph, 2000; Schanzer, Dominguez, Shrout, & Caton, 2007).
- Lack of familial support increases the risk of episodic and chronic homelessness and manifests as disconnection from family, childhood placement in foster care or other institutions (27 percent), and childhood physical and/or sexual abuse by family members (25 percent; Burt et al., 1999).

- Thirty-eight percent of people who were homeless and received services in 1996 lacked a high school diploma or equivalent (Burt et al., 1999).
- Incarceration is common among people who have experienced homelessness (54 percent of those who received services in 1996; Burt et al., 1999). Many individuals leaving prison have no place to live and seek housing through community resources for homelessness.

Are There Different Types of Homelessness?

Surveys conducted with people who are homeless indicate that there is a continuum of homelessness (Burt, Aron, Lee, & Valente, 2001). This section offers brief explanations of the types of homelessness, the prevalence of each, and illustrative vignettes.

Transitional homelessness

A first or second episode of homelessness, ranging from a few weeks or months to less than a year, is considered transitional homelessness. About half of the homeless population falls into this category, including many families who are homeless. Families are likely to qualify for public assistance programs, so they are less likely to be homeless or to be homeless for long periods. People leaving prison or jail may be transitionally homeless.

Episodic homelessness

Episodic homelessness means entering and leaving homelessness (e.g., shelters) repeatedly. Between episodes of homelessness, a person might be tenuously housed (in his or her own housing or living with friends/relatives) and at high risk for becoming homeless again. About one fourth of people who are homeless have gone in and out of homelessness numerous times (Burt et al., 2001).

Chronic homelessness

About a quarter of people who are homeless have been continuously so for at least 5 years (Burt et al., 2001). Engaging people who are chronically homeless in housing and other services requires willingness to provide housing and services that are attractive to clients.

How Do Communities Respond to Homelessness?

Homelessness is a broad social problem, and

Mikki

Mikki is **transitionally homeless**. Her boyfriend (who is also the father of her youngest child) has left her. He promised financial support for Mikki and the two children, ages 7 and 3, but only provided money for a few months. Mikki was evicted from her apartment 3 weeks ago and has been living with her children in the family car, which won't start. When the children come down with bad colds, she takes them to the community health center.

Mikki has become progressively more depressed as a result of her breakup and the stress of homelessness. She has begun drinking at night to sleep. The case manager in the community health center helped her arrange temporary emergency housing until more stable transitional or permanent supportive housing can be arranged. He also referred her for a psychiatric evaluation and worked with the school system to provide supportive and preventive services to the children. One of his primary goals has been to intervene before a pattern of long-term homelessness is established. The case manager is also cognizant that Mikki's co-occurring depression and substance abuse must be addressed as part of a larger treatment plan that includes adequate housing, employment, financial support, child care, and services for mental health and substance abuse treatment.

Part 1, Chapter 2, describes how the caseworker helps Mikki obtain these services.

Roxanne

Roxanne is **episodically homeless**. She has a history of illicitly using and selling extended-release oxycodone and other opioid drugs. She has been diagnosed with antisocial personality disorder. She lived with friends until they tired of her drug use and erratic behavior. Roxanne now lives in single room occupancy (SRO) housing. Roxanne's drug use and erratic behavior make it hard for her to hold a job. She occasionally engages in prostitution and sells pain pills for income. She's been told not to bring customers to the SRO but sometimes brings them anyway. Failing to follow the rules puts her at risk of ending up back on the street. Roxanne's behavior and risk of eviction predispose her to victimization. Although currently housed, Roxanne has a long history of episodic homelessness beginning in childhood. As an adult without family, she is ineligible for most safety-net programs, so she is at risk for continued episodic homelessness.

Part 1, Chapter 2, shows how her counselor helps ready her for services to reduce risk of homelessness, address pervasive trauma symptoms that interfere with life functioning, and maintain commitment to mental health and substance abuse treatment and recovery.

communities have established a range of strategies to manage homelessness. On one hand, faced with demands from business owners and other citizens, some public officials have turned to criminal justice solutions to respond to street homelessness. Legal measures include prohibition of sleeping, camping, begging or panhandling, and storing personal possessions in public areas. Other trends restrict serving food to the poor and homeless in public places. Such measures can impede provision of services and create additional barriers to recovery (such as criminal records), which can delay access to housing and decrease eligibility for employment.

On the other hand, a growing number of States and communities are adopting progressive initiatives, including the development of drug, mental health, and homelessness courts, which divert people who are homeless from incarceration; mobile crisis teams working in tandem with police trained to respond to people who are homeless; programs to bridge reentry into the community for people exiting the criminal justice system; and specialized community services, such as crisis intervention beds, sobering stations, and homelessness assistance centers. As of August 2007, more than 300 communities had formal plans to end chronic homelessness (see the U.S. Interagency Council on Homelessness [USICH] Web site at http://www.usich.gov) and were offering a wide range of treatment and housing services to meet this goal.

A particularly progressive initiative is the provision of permanent and transitional supportive housing, which offers stable, safe, affordable, long-term housing for individuals and families who would otherwise be homeless. Permanent supportive housing provides long-term hous-

Francis

Francis is **chronically homeless**. He has lived in a subway tunnel for some time and is known to the staff of the local homeless program. It's been more than 5 years since he had a home. His medical records indicate that he has an intelligence quotient (IQ) of about 70, possible cognitive impairment from an old injury, and diabetes. With cold weather predicted, the outreach and engagement team want to see how he is functioning, if he has immediate needs, and whether he will accept shelter.

Techniques for engaging Francis into appropriate services are illustrated in Part 1, Chapter 2. The importance of cultural competence in working with Francis is shown in the vignette.

ing and supportive services to people with physical disabilities, mental illness, or other long-term impairments (such as developmental disabilities) that limit the individual's ability to maintain housing without assistance. Transitional supportive housing provides stable housing along with social and health services but is more often used with individuals and families in crisis or transition.

PSH helps eligible people find a permanent home and obtain needed mental health and substance abuse treatment services. An important component of PSH is that housing is not contingent on whether an individual obtains mental health, substance abuse, or other services, but rather, allows the individual to decide when and how to seek out services. PSH supports individuals in choosing their own living arrangements and helps them access services based on the support they need at any given time.

An example of a candidate for transitional housing is an individual leaving addiction treatment who has no place to live, needs a sober environment to support recovery, and can be expected to regain employment in the near future. Transitional housing is normally limited to 2 years. Some of the social and health services frequently offered in supportive housing include mental health and substance abuse treatment, employment services, job training, life skills training, interpersonal skills development, medical case management, and coping skills training. Transitional and permanent supportive housing can range from a rooming house with individuals having their own rooms to clusters of small apartments in a single location to scattered-site programs in which rent subsidies are provided for individuals and families to have a home in the greater community.

A major support for persons in need is SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) program. Administered by the Center for Mental Health Services (CMHS), PATH is part of a formula grant to States and provides minimal housing assistance for individuals. PATH funds help individuals with SMI and co-occurring mental and substance use disorders access needed services. PATH provides technical support and funding for outreach, screening and diagnostic treatments, community mental health services, alcohol and drug treatment, staff training, case management, health referrals, job training, and educational and housing services.

There are approximately 600 local PATH organizations that work to engage behavioral health service agencies and housing programs. Nearly all States use money from PATH formula grants to contact and engage people who are disconnected from mainstream resources. This includes collaboration with the Social Security Administration to support access to Social Security Income benefits among homeless populations with mental illness, as well as collaborative planning efforts with local continua of care to coordinate homelessness services and to end homelessness. According to the PATH Web site (http://pathprogram.samhsa.gov/), PATH providers work with service delivery systems and use effective practices by:

- Partnering with Housing First and permanent supportive housing programs.
- Providing flexible consumer-directed and recovery-oriented services.
- Improving access to Social Security and other benefits.
- Employing consumers or supporting consumer-run programs.
- Partnering with medical providers, including Health Care for the Homeless and community health centers, to integrate mental health and medical services.
- Improving access to employment.

- Using technology, such as handheld electronic devices, electronic records, and Homeless Management Information Systems (SAMHSA, n.d.; USICH, 2011).

Vignette 7—Sammy in Part 1, Chapter 2, of this TIP—illustrates how PATH can be of assistance for clients with SMI who are homeless. For more information about PATH, related resources, and a list of PATH grantees, visit the PATH Web site (http://pathprogram.samhsa.gov).

Homelessness and Behavioral Health Services

Behavioral health problems are common among people who are homeless, and the risk of chronic homelessness increases when substance use or mental problems are present. Substantial progress toward recovery and self-sufficiency may require significant engagement efforts and repeated attempts at treatment and housing rehabilitation. In addition, relapse during substance abuse treatment may create barriers to a variety of services, including transitional and permanent supportive housing (Kertesz et al., 2007). Furthermore, clients who relapse and exhibit symptoms of their mental disorder (e.g., a person with bipolar illness who relapses into a manic episode) may find their opportunities for housing restricted. People who are homeless or at risk for homelessness and have a substance use or mental disorder are often cut off from social supports and need services ranging from safe and stable housing, food, and financial assistance to medical care, mental health treatment, child care, education, skills development and other preventive services, employment, screening and early intervention, and recovery support. It is important that you, as a behavioral health service provider, participate in a system of care that responds specifically to your clients' wide-ranging needs. Comprehensive recovery efforts must include not only housing, but also supportive mental health, substance abuse, medical, occupational, and social services.

The Special Rewards of Working With People Who Are Homeless

As a behavioral health service provider, working with individuals who are homeless may mean entering a world you have previously seen only from a distance. It is common to have concerns and anxieties when first beginning to work with people who are homeless. In providing services for this population, you will likely face some complex and challenging problems. At the same time, however, your work with people who are homeless can be quite rewarding; their gains can be dramatic as they move through their personal recovery processes.

For many, working with clients who experience homelessness provides the opportunity to look inside a world that may be very different from their own and to learn life histories that depart substantially from those of most people they know. Living on the streets requires substantial skill, strength, and resourcefulness. People who are homeless have lessons to teach about being survivors in difficult and often hostile environments.

Perhaps surprisingly, some people who are homeless are de facto experts on the service systems in their communities. These individuals have valuable firsthand information about where to go (and not go) to seek food, shelter, medical services, and other resources. You can gather valuable information about community resources from these people.

In working with this population, you have the opportunity to make a real difference for some of your community's most vulnerable and disenfranchised citizens:

- *With your help, a person's immediate risk of harm can be substantially reduced.* Assisting

your clients in obtaining even temporary housing will substantially reduce their risk of victimization, morbidity or mortality from exposure, and exacerbation of mental illness. For clients with existing health problems, temporary housing can mean the opportunity to obtain needed medical care.

- *You can help people realize elusive lifelong goals.* For many persons who are homeless, life in stable housing may feel like a distant or unattainable dream. But this transition can be made, and you can be one of the change agents that makes it happen. See Vignette 1 in Chapter 2 (Juan).
- *You can help people transform their lives.* The difference between being homeless and being housed affects almost all aspects of a person's life, including increasing the likelihood of advancing personal recovery from mental illness and substance abuse, as is the case with René in Vignette 5 in the next chapter, and reducing the risk of future substance abuse and mental disorders, especially for children who are homeless (see Troy and Mikki in Vignettes 4 and 6, Part 1, Chapter 2, of this TIP).
- *You will come to understand, firsthand, one of our Nation's pressing social problems.* The Francises, Roxannes, and Mikkis of your community are not able to work for change, at least not until they are further along in recovery. Working with them and actively helping them navigate and benefit from a layered service system is rewarding work. Moreover, through your experiences and your understanding of their world, you can help improve the behavioral health system that reduces homelessness and the hardships faced by people who are homeless.

Counselor Competencies for Working With People Who Are Homeless

The knowledge, skills, and attitudes for working effectively with people who are homeless in all phases of rehabilitation are presented in this section (see also the Center for Substance Abuse Treatment's [CSAT's] Technical Assistance Publication 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* [CSAT, 2006a] for more information on counselor competencies). Some specific knowledge, skills, and attitudes helpful for your work with clients with a substance use disorder and/or mental illness and facing or experiencing homelessness are listed below. All of the discussion below presumes that you, as a behavioral health service provider, possess sufficient knowledge and skills and appropriate attitudes for working with people with mental illness and/or substance use disorders. Some competencies will be more relevant to either treatment or prevention workers. However, anyone who provides behavioral health services needs at least a basic level of competence in each area discussed in this section to ensure the delivery of *integrated* care and services to the whole person.

Knowledge

To provide effective services to people who are homeless or at risk of becoming so, behavioral health workers should possess knowledge of:

- Homelessness: its impact on people and families, how it acts as a barrier to services for other problems, such as substance abuse and mental illness, and how, without intervention, it can become self-perpetuating.
- How substance abuse, mental illness, and homelessness interact to limit clients' opportunities for growth and change.

- Medical comorbidity in homeless populations and how to help people address physical wellness.
- The pervasiveness of physical and sexual trauma within homeless populations and the effects of trauma in limiting opportunities for recovery from mental illness and substance abuse.
- The effects of experiences of incarceration among clients who are homeless.
- Local homelessness assistance services and available community resources and how to help clients with a mental illness or a substance use disorder access them.
- The process of recovery from substance abuse, mental illness, and homelessness, including appropriate interventions at different stages in recovery.
- The interaction of co-occurring substance use and mental disorders and homelessness.
- Prevention and treatment methods that have been shown to be effective or promising with people with substance abuse and/or mental illness who are homeless.
- The fact that having a substance use disorder or mental illness can itself affect the process of relationship development and trust in others.
- Types of housing services that might be useful and how to access these services.

Skills

Using the following skills will allow behavioral health service providers to work more successfully with clients who are experiencing homelessness or the threat of it:

- Use techniques for creating trusting, collaborative relationships with members of a population that experiences high rates of social disaffiliation; for identifying client strengths; and for helping clients empower themselves to initiate and sustain stable housing and recovery.
- Demonstrate specific outreach skills for people who are homeless, particularly those who are chronically homeless and have a substance use and/or mental disorder.
- Conduct an initial screening and needs assessment for clients who present with a substance use and/or mental disorder and are homeless or are facing homelessness.
- Recognize the effects of psychological trauma on trust, willingness to persevere and accept help from others, and a variety of other personal and interpersonal dynamics that are important in treatment and recovery.
- Support clients' early changes (e.g., entering treatment, recognizing/addressing mental and substance use disorders, finding temporary housing, obtaining needed medical care, getting financial support).
- Develop person-centered treatment and/or prevention plans that consider the whole person and his/her individual needs, including early intervention for emerging mental and substance abuse problems, mental illness and substance abuse treatment and rehabilitation, and programming to build resiliency and enhance quality of life by developing social and occupational skills.
- Use case management skills in helping people make contact with and continue accessing needed community resources, including prevention programs.
- Retain clients in treatment and prevention programs by maintaining rapport, motivation, and hope and by helping them work through the obstacles they face in recovery.
- Develop realistic, individualized relapse prevention and recovery management plans that include specific "how-to" steps to follow if the client experiences a recurrence of behavioral health symptoms, homelessness, or other life problems.

- Collaborate with other service providers, family members, and social supports to:
  - Help people who are homeless access services.
  - Better understand needs and strengths.
  - Ensure appropriate care and smooth transitions.

Attitudes

Behavioral health workers engaged in providing services to clients who are dealing with homelessness can benefit from certain attitudes. For example:

- Accept and understand powerful emotional responses to client behavior and address these responses in supervision.
- As a precondition to a positive working relationship, meet clients where they *are* rather than where they *should be.*
- Appreciate that people must assume responsibility for their own recovery trajectories, although they sometimes make choices that do not appear to be in their own best interests.
- Trust that change begins with small steps that are self-reinforcing and aggregate to larger changes.
- Understand that all change is incremental and that many clients who are experiencing homelessness are on a long recovery pathway.
- Recognize that consistency and reliability can counteract the disaffiliation and mistrust experienced by many persons who are homeless and have substance use or mental disorders.
- Appreciate that work with people who are homeless and in need of treatment requires collaboration and cooperation among a range of service professionals and peer supports.

Self-Assessment of Attitudes Toward People Who Are Homeless

Attitudes toward homelessness, substance abuse, and mental illness vary widely. Many of these beliefs originate in childhood and influence your perception of these problems. These perceptions, whether beneficial or limiting, tend to be reinforced as you encounter people dealing with substance use or mental disorders and homelessness. It is important for you to be particularly aware of your attitudes and beliefs regarding these topics. Likewise, it is important to remember that not everyone holds your particular views or attitudes.

Behavioral health service providers work with people who are homeless and have a substance abuse or mental health diagnosis in many different settings: street outreach, mobile crisis teams, drop-in centers, shelters, assertive community treatment (ACT) teams (see p. 143), permanent supportive housing programs, criminal justice environments, healthcare facilities, and other community behavioral health prevention and treatment programs. This work presents many challenges along with opportunities for professional growth. One of the important challenges is to monitor and be aware of your personal attitudes and beliefs about your clients. This section presents:

- Opportunities to consider your reactions to and assumptions about people who are homeless.
- Myths people often believe about people experiencing homelessness.
- Methods for managing responses when working with this population.

Reactions and assumptions about people who are homeless

Three people with mental or substance use disorders who are homeless were described earlier in this chapter. Your reactions, assumptions,

and beliefs influence how you might interact with each one. After reading their descriptions, some of the reactions you might experience as you imagine a conversation with Mikki, Roxanne, or Francis include:

- Empathy (I have an emotional understanding of what it's like to be in his or her shoes).
- Sympathy (I feel sorry for him or her).
- Fault finding (Why doesn't he or she… like everyone else?).
- Curiosity (I wonder what his or her story is?).
- Aversion (I don't want to meet him or her).
- Fear (This person may hurt me in some way).

Your personal experiences and history play an important role in how you perceive and work with people who are homeless and have substance use or mental disorders. Ask yourself the following:

- What is my personal and family experience with substance abuse, trauma, mental illness, and homelessness?
- What personal experiences do I have with these problems, and how do those personal experiences—for better or worse—affect my work?
- What is my emotional reaction to people who have a mental or substance use disorder and are homeless?
- How comfortable do I feel providing services to people with these problems, and what are the areas of discomfort that I experience?
- What did I learn about homelessness, substance use, and mental illness growing up?
- What beliefs and attitudes do I hold today that might challenge or limit my work with persons who are homeless and have a substance use or mental disorder?

Myths and realities about people who are homeless

When providers have insufficient information about social and health problems, myths may arise about the nature of the problems, the kinds of people who are likely to be affected by them, and how the problems are best addressed. Homelessness, and the relationship between homelessness and behavioral health problems, are not exceptions. Care providers are not exempt from the myths that universally abound. Your awareness and management of attitudes and beliefs that may interfere with your work will result in personal growth and better relationships with clients. Following are some common myths about people who are homeless.

Myth #1. People choose to be homeless.

Reality: Most people who are homeless want what most people want: to support themselves, have jobs, have attractive and safe housing, be healthy, and help their children do well in school.

Myth #2. Housing is a reward for abstinence and medication compliance, and society shouldn't house people who have active substance use or mental disorders.

Reality: Housing may be the first step to becoming abstinent and/or entering treatment to address a variety of problems. From a public health perspective, adequate housing reduces victimization, hypothermia or hyperthermia, infectious diseases, and other risks to the population as a whole.

Myth #3. People who are homeless are unemployed.

Reality: Many people who are homeless are employed full or part time. According to data from the National Survey of Homeless Assistance Providers and Clients (Burt et al., 1999), 44 percent of people who were homeless and

received services did some work for pay in the month before being surveyed. A single-day count of people who were homeless in an urban area of Washington State found that 20 percent were employed at least part time (Putnam, Shamseldin, Rumpf, Wertheimer, & Rio, 2007).

Myth #4. There are few homeless families.

Reality: To describe the full impact of homelessness, episodes of homelessness, and the effects on children of tenuous living situations (such as the "doubling up" of one family in the home of another family), the National Center on Family Homelessness (NCFH) used refined methods for estimating the number of children exposed to these burdensome and stressful difficulties. NCFH determined that in 2010, 1.6 million children in America were exposed over the course of the year and 200,000 on any given night (NCFH, 2010).

Myth #5. People who are homeless aren't smart enough to make it.

Reality: Keeping things together while homeless takes ingenuity and experience. People

The Impact of Homelessness on Children and Families

Homelessness results in a loss of community, routines, possessions, privacy, and security. Children, mothers, and families who live in shelters must make significant adjustments to shelter living and are faced with other problems, such as feeling ashamed of being homeless and accepting help, the anger and confusion of being relocated, and having to adjust to a new school and other new routines.

The stress related to these risks adds to the stress resulting from homelessness itself and can impede recovery due to ongoing traumatic reminders and challenges:

- The experience of homelessness puts families at greater risk of additional traumatic experiences, such as assault, witnessing violence, or abrupt separation.
- Children, parents, and families are stressed not only by the nature of shelter living and the need to reestablish a home, but also by interpersonal difficulties, mental and physical problems, and child-related difficulties such as illness.
- The stresses associated with homelessness can worsen other trauma-related difficulties and interfere with recovery due to ongoing traumatic reminders and challenges.

Children are especially affected by homelessness:

- Children who are homeless are sick twice as often as other children and suffer twice as many ear infections, four times the rate of asthma, and five times more diarrhea and stomach problems.
- Children who are homeless go hungry twice as often as children who have homes.
- More than one fifth of preschoolers who are homeless have emotional problems serious enough to require professional care; less than a third receive any treatment.
- Children who are homeless are twice as likely to repeat a grade as those with homes.
- Children who are homeless have twice the rate of learning disabilities and three times the rate of emotional and behavioral problems compared with children who are not homeless.
- Half of school-age children who are homeless experience anxiety, depression, or withdrawal compared with 18 percent of children who are not homeless.
- A third of children over age 8 who are homeless have a major mental disorder.

These are not only challenges in themselves, but also may act as "secondary adversities," putting a child at greater risk for trauma reactions and making recovery difficult. For more information and a list of resources about providing care and improving access to services for children and families who have been traumatized and/or are homeless, visit the National Child Traumatic Stress Network Web site (http://www.NCTSNet.org).

Source: Bassuk & Friedman, 2005.

who are homeless often have well-developed street skills, resourcefulness, and knowledge of the service system.

Myth #6. Those with substance use or mental disorders need to "bottom out," so homelessness is okay and provides a motivator to make behavioral changes.

Reality: People who have substance use and mental disorders are more responsive to interventions before they become homeless or when placed in housing.

Myth #7. Everyone stands an equal risk of homelessness.

Reality: Although any of us could find ourselves homeless in our lifetime, some people are at higher risk than others. If we can identify people at special risk of homelessness, we may be able to intervene earlier and prevent the devastating effects experienced by people who are homeless and have accompanying mental and/or substance use disorders.

Myth #8. All clients with substance use and mental disorders who are homeless require extensive, long-term care.

Reality: The process of recovery from substance abuse and mental illness is an ongoing and sometimes lifelong process, yet healing often begins with short-term, strategic interventions. Screening, brief intervention, and referral to treatment (SBIRT; see the section on p. 35 for more information) is a proven method for early intervention with substance use and mental disorders, and it can significantly reduce the impact and progression of illness.

Self-Care for the Behavioral Health Service Worker

The intensity of the work with people who are homeless and have mental and/or substance use disorders can lead to burnout, ethical dilemmas, and a sense of being overwhelmed by your work. Your personal history is unique; however, commonalities of experience in working with people who are homeless allow some generalizations about the need for self-care. Some of the actions you can take are consistent across a variety of roles, personalities, and circumstances.

Common responses to working with people who are homeless

Working with people who are homeless may entail addressing emergency situations, complex case management demands, severe and persistent symptoms, and refusal of services. The pace of the work may be a stressor, as some people who are homeless are reluctant to engage in services and require a lot of time and patience to develop trusting relationships. You may experience stress or unrealistic expectations when working with this population. Other common reactions include:

- Considerable anxiety regarding clients in dangerous situations (e.g., refusing shelter on frigid nights).
- A strong desire to repeatedly try to persuade someone to go to treatment because you are concerned about his or her pace in recovery.
- Frustration and strong urges to use involuntary measures (e.g., police transport to the hospital) despite no clear risk of imminent danger to self/others when a severely impaired person is slow to engage.
- Conflict over family members' reactions, given their experience (e.g., burnt bridges, extreme feelings of guilt) with an individual's past behavior.
- Feeling overwhelmed or frightened by your client's irritability, anger, and frustration. An example of deescalating a person in the midst of an intense emotional reaction is given in Vignette 3 (Roxanne, Part 1, Chapter 2).

- Thinking about violating ethical boundaries or agency policies to meet the immediate needs of a person who is homeless (e.g., give them personal funds). Feelings of helplessness or a sense of guilt about a person's situation may add to the temptation to violate boundaries and policies.
- A struggle to understand and appreciate the survival skills of a person who is homeless, particularly when his or her choices and behaviors (e.g., distrust, agitation) create barriers to receiving services.
- Guilt about going home at night while a client is sleeping on the street.
- Anger or frustration about missed appointments, which indicate resistance to engaging with services.
- Reluctance to continue providing services to someone whose priorities conflict with your ideas about their needs (priority to find drugs rather than adequate housing, resistance to obtaining medical care for an immediate problem).
- Frustration and feelings of ineffectiveness when your efforts to help seem to be unappreciated.
- A sense of disconnection from clients who seem demanding, needy, miserable, or overwhelmed.

Your own experiences also play a role in your responses to people who are homeless, and these experiences may interfere with your work, particularly if:

- A member of your family has a substance use or mental disorder and/or has experienced homelessness.
- You have trouble differentiating your own recovery process from that of your client.
- You have ever been homeless or faced with the prospect of being homeless.
- You see yourself as someone who has overcome the odds and pulled yourself up "by the bootstraps."
- It is difficult for you to work with people who are overtly angry, excessively passive, or insistent about doing things their way.
- The experience of working with people who are homeless is new to you.

Whether or not you have had these types of personal experiences, you may struggle with your reactions when working with this population, especially when dealing with stressful situations.

Managing responses to working with people who are homeless

Managing your responses to feelings and stressors is easier if you develop and maintain sources of personal support (CSAT, 2006a):

- Learn to recognize when you need help (both technical and personal); ask for it.
- Work in teams and establish networks; discuss feelings and issues with teammates to lower stress and maintain objectivity.
- Be open and sensitive to differences of attitude or opinion among your colleagues regarding individuals who are homeless and the problems they face.
- When you find yourself being angry, critical, or dismissive toward the feelings or needs of a person who is homeless, consider whether this is a sign of an attitude conflict, job burnout, or some other dynamic related to your work.
- Work closely with your supervisor and be open about any difficulties (for more information about the benefits and process of clinical supervision, refer to TIP 52, *Clinical Supervision and Professional Development of the Substance Abuse Counselor* [CSAT, 2009b]).

Managing feelings and stressors is easier if you maintain healthy boundaries between your work and personal life:

- Resist the urge to bring work home.

- Don't spend your free time at work or with your clients.
- Resist the urge to be a friend or feel responsible for rescuing the people you serve from homelessness.
- Recognize that your role is to help people help themselves and enable them to address their life problems, not to take responsibility for their problems.

Stages of Change, Recovery, and Rehabilitation

This section presents several frameworks for helping people who are homeless by describing three important aspects of a trajectory out of homelessness:

- Stages of change (Prochaska, DiClemente, & Norcross, 1992). This transtheoretical model describes the process of behavioral change, beginning with precontemplation and continuing through maintenance. It is often used to reflect the process of change for people with substance use disorders.
- Critical stages of recovery (Townsend, Boyd, Griffin, & Hicks, 2000). The critical stages of recovery model, often applied to describe the change process with serious mental illness, emphasizes social and interpersonal connectedness and the relationship of the individual with systems that provide care. The model describes movement through four levels, from dependence through interdependence.
- Stages of homelessness rehabilitation (McQuistion & Gillig, 2006). This model describes the logical progression of rehabilitation—a process of moving from engagement though intensive care and into ongoing rehabilitation. It describes the consequences of homelessness in a holistic manner, recognizing that homelessness is not only the lack of adequate housing but also the psychological, emotional, occupational, interpersonal, health, and other effects on an individual's or family's ability to function.

Stages of Change

Stages of change, which comprise the key organizing construct of the transtheoretical model of change, inform effective interventions to promote behavior change. Although they have traditionally been associated with substance misuse, they may also be applied to a person's experience in coming to grips with serious mental illness. The stages of change are equally applicable to prevention or treatment interventions, although in prevention, behavior change may involve risk or protective factors (e.g., parenting skills, physical inactivity) rather than problem behavior per se.

Most people cycle through the stages more than once, and movement through the stages can fluctuate back and forth (Exhibit 1-3). The stages are:

- Precontemplation—Clients view behavior (e.g., substance use, psychological symptoms, healthcare choices) as unproblematic and do not intend to change. Your focus

Exhibit 1-3: Stages of Change

Source: Prochaska & DiClemente, 1986. Adapted with permission.

on changing behavior at this stage may alienate clients. Instead, appropriate interventions help clients engage in services and become ready to consider change.
- Contemplation—Clients think about whether to change behavior, become aware of problems their behavior causes, and experience ambivalence about their behavior.
- Preparation—Clients decide to make a change and have perhaps already begun to change problematic behavior.
- Action—Clients make a clear commitment to change; they engage in activities as alternatives to problem behaviors, avoid high-risk situations, and develop relationships that reward their changed behavior.
- Maintenance—Clients have sustained new behaviors for at least 6 months. They sustain and further incorporate changes achieved in the action stage and are actively working on supporting their recovery.

Two other stages of the transtheoretical model are sometimes identified: relapse and termination. Relapse is a return to problem behaviors. Most relapses to substance use occur within 3 months of behavior change; risk of relapse then begins to decline (Connors, Donovan, & DiClemente, 2001). Termination occurs when new behaviors are thoroughly stabilized and there is a compelling belief that a return to the problem behavior is highly unlikely (see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999b] for an indepth discussion of stages of change).

Regardless of the model for understanding change, it is important to remember that people are often in different stages of change for different issues. For example, a person may be willing to accept housing or medical care (preparation stage of the transtheoretical model) while not yet thinking about substance abuse or mental health treatment or broadening coping skills or community involvement (precontemplation stage). The provider's challenge is to understand and respect the service recipient's stage of readiness and provide interventions and services that facilitate forward movement. Skilled providers recognize that readiness to change some behaviors might provide an opportunity to explore ambivalence and enhance readiness to change others; for example, persons may be willing to seek housing but not immediately address substance use behavior. When they do recognize that housing issues are intertwined with substance use, they may be more willing to explore the pros and cons of their use.

As people move toward the action stages in any model, they become ready for more intense services, which often require more active collaboration with clients and may be offered in more structured housing and treatment or prevention programs where individual responsibility for completion of tasks and behavior change yields successful outcomes.

Critical Stages of Recovery

Whereas the stages of change model addresses psychological readiness for behavioral change, the stages of recovery model addresses developmental goals that are more closely related to mental health recovery, the degree and nature of social connectedness, and the relationship between an individual and the service delivery system. As clients engage in their recovery process, they begin in a state marked by high dependence on the human services system and other community supports but are paradoxically unaware of that dependence. As they gain greater mastery over their recovery, they may remain dependent on support from others, yet become *aware* of that dependence. Following this is a stage of awareness and relative *independence* from these structures, and finally, a stage characterized by a sense of *interdependence,* in which they are aware of challenges and can use natural support systems, both formal

and informal, realizing that they are also actively contributing to the social environment. (Townsend et al., 2000.)

The stages of recovery model recognizes the right of people to live in the community and to choose their lifestyle. It is premised on a number of additional guiding principles. Perhaps most important is that a client directs and manages his or her recovery process. A corollary of that is that behavioral health service providers need to be wary of their tendency to encourage clients to be dependent on the treatment system (Townsend et al., 2000). As part of a community system of care, the behavioral health service provider has an important role in each of these stages to promote recovery (Exhibit 1-4).

Processes in recovery from substance use and mental disorders

In recovery, people actively manage substance use and/or mental disorders and seek to transcend these experiences as they build or reclaim meaningful lives in the community (Davidson

Exhibit 1-4: Behavioral Health Service Provider Roles and Best Practices According to Stage of Recovery

Stage	Service Provider's Role	Best Practices To Facilitate Recovery
Dependent/Unaware	• Demonstrate hope • Encourage self-acceptance • Educate about behavioral health problems and the benefits of a recovery plan • Engage family and other social supports	• Build relationship by listening, valuing, and accepting client as a worthwhile person • Collaborate with client in managing behavioral health problems • Build rapport with family/others • Link to services and benefits
Dependent/Aware	• Promote readiness to make choices about life roles/goals • Educate family about available choices • Offer support in designing a recovery plan	• Involve client with groups that address his or her specific needs • Educate about behavioral health problems and relevant coping skills • Help with choosing goals
Independent/Aware	• Help develop life roles/goals • Encourage individual coping strategies to deal with symptoms and distressing experiences • Support medication management and use of recovery plan • Encourage appropriate support from families and others	• Assist with connection to community resources • Work on recovery plan, recovery support, coping skills, and crisis plan
Interdependent/ Aware	• Work with client and support system to support life goals • Help with community resources • Review recovery plan regularly • Support interdependence in community	• Support continuing recovery • Advocate use of community resources • Encourage involvement in community activities

Source: Townsend et al., 2000.

& White, 2007). The term "recovery" may have somewhat different meanings in substance abuse treatment settings than it does in mental health settings. For instance, many clients in substance abuse recovery may say they are never fully recovered from their illness and are "only one drink away from a drunk," whereas individuals with a single major depressive episode in their history may consider themselves recovered, even "cured" of their illness. In either case, it is important to know how each individual client understands these terms and how they apply to the recovery process for the specific individual.

Considering the broader framework of recovery—integrating the recovery process from substance use disorders with that of mental disorders—Davidson et al. (2008) obtained information from people in recovery about their experiences. For most of the respondents, recovery meant taking an active role, profoundly changing the way they lived their lives, opening up to new learning, and becoming more flexible. The processes the authors describe are presented in Exhibit 1-5. The authors recognize that recovery is not linear, but they believe that processes represented together on a single line in the exhibit occur more or less simultaneously. This progression also suggests that some recovery strategies may be more useful at some points in the process than others. For example, early in recovery, a behavioral health service provider might want to focus on strengthening mutual support systems and fostering a belief in recovery.

These processes are also valid for clients entering homelessness services from the criminal justice system. Developed in partnership with people in recovery, these processes reflect challenges people face in recovery and solutions for them. Your role and that of the program administrator is to help articulate and then support clients' efforts in recovery by helping them identify acceptable strategies and resources to confront these challenges.

Prevention activities can play a central role in recovery, especially those that relate to skills

Exhibit 1-5: Substance Use and Mental Disorder Recovery Processes

Source: Davidson et al., 2008.

development and wellness self-management. In addition, prevention programs can adopt and benefit from a recovery orientation when working with individuals who are homeless.

The process, dynamics, and important interventions related to recovery are addressed in detail in the planned TIPs, *Building Health, Wellness, and Quality of Life for Sustained Recovery* (SAMHSA, planned b) and *Recovery in Behavioral Health Services* (SAMHSA, planned e). Refer to these TIPs for more information on supporting long-term recovery.

Stages of Homelessness Rehabilitation

Stages of homelessness rehabilitation refer to the different types of care a client with behavioral health problems, and his or her family, may receive while moving toward housing stability. Your work may involve clients at any of these stages. For individuals who are homeless, attaining housing and financial stability are inextricably tied to other aspects of social support and to rehabilitation from disabling behavioral health conditions. Depending on the services an individual who is homeless needs, stagewise interventions may emphasize outreach and case management, screening and evaluation, crisis intervention, clinical preventive services, preparation for treatment, treatment planning, relapse prevention or recovery promotion, or ongoing counseling.

Your existing skills in providing treatment and prevention services in behavioral health settings will be invaluable and can often translate directly into working with people with mental and/or substance use disorders who are homeless. Nevertheless, you may need to develop some specific skills for work in this area. It will be necessary to coordinate your services with those provided by staff in other homelessness programs and health and social service organizations. Your services and the services provided by other health and social service organizations are often delivered across stages, with service transition points being particularly high-risk periods for dropout. The stages of homelessness rehabilitation are:

- Outreach and engagement.
- Transition to intensive care.
- Intensive care.
- Transition to ongoing rehabilitation.
- Ongoing rehabilitation.

The amount of time a person spends in any of the stages of homelessness rehabilitation depends on barriers to providing and accepting services—such as availability of appropriate housing options, severity and chronicity of substance use disorders and symptoms of mental illness, and availability and acceptability of social supports for changing problematic behaviors. Progress through the stages of rehabilitation is not steady. Clients may drop out, relapse in their substance use, and need outreach and reengagement several times before achieving ongoing homelessness rehabilitation. For this reason, this TIP assumes that motivation for changing problematic behaviors will fluctuate, that behavioral health symptoms may recur, and that a client may return to homelessness during any phase of rehabilitation.

Outreach and engagement

Engagement is the first stage of work with people who are homeless (McQuistion, Felix, & Samuels, 2008). Its goal is to facilitate the individual's movement through the early stages of behavior change (Prochaska et al., 1992). Approaches during this phase include active outreach to prospective clients and engagement services—including capturing prospective clients' interest in a variety of homelessness services, as well as substance abuse, medical, mental health, and social services; gaining the prospective client's trust; and increasing motivation for change. For families

who are homeless, the prospect of preventive services for children may be especially attractive. During this process, you should identify and attempt to meet basic needs for shelter and safety, and you should attend to immediate health concerns.

For some persons who are homeless or at risk for becoming so—those coming from criminal justice settings or those being discharged from treatment programs—outreach may not be a particularly difficult issue, but engagement in social, health, and continuing prevention and recovery services may present more of a problem. Persons with transitional homelessness may not perceive the need for additional services beyond lodging, seeing their stay in a shelter or other homeless housing program unrealistically as a temporary transition to getting a place of their own. Additionally, clients recently in treatment for mental and substance use disorders may not recognize the effect of their impending homelessness on substance abuse and mental health recovery and across all other aspects of their lives.

As a behavioral health worker, you can play an important role in outreach by acknowledging homelessness as a significant element in when and how people can access treatment, by recognizing the needs of people who are homeless for preventive and basic services, and by developing productive, trusting, and supportive relationships with people who are homeless and come to you for services.

Transition to intensive care

People enter the intensive care phase of homelessness rehabilitation when they agree to accept health and/or financial benefits; medical, substance abuse, and/or mental illness treatment and prevention services; and, frequently, housing. This transitional phase is a high-risk period during which a large percentage of individuals drop out of services. The transitional phase requires intensive support (e.g., intensive case management, critical time intervention) and your acceptance that some people may have increased ambivalence and may not attend program sessions or keep appointments or commitments. Essential elements in this phase include locating clients or program participants when they fail to make contact, making phone calls, and providing immediate tangible benefits (e.g., food, safe shelter, bus fare).

Accordingly, you may have to adapt traditional assumptions about and approaches to service provision when a client is in the transitional phase of homelessness rehabilitation (e.g., assuming clients will make and keep appointments; assuming program participants will attend sessions; assuming individuals have transportation to service settings; having standard time lengths for counseling, psychoeducational, or anticipatory guidance sessions). You may need to exercise greater persistence and advocacy with these individuals. On the other hand, the skills you regularly use, such as maintaining a trusting and supportive relationship, working with resistance, or adapting to specific needs or concerns can be a significant benefit in working with individuals in this stage who are homeless.

Intensive care

As its name denotes, the primary focus of intensive care is a comprehensive but carefully synchronized orchestration of homelessness rehabilitation, including treatment for mental and substance use disorders, access to benefits, active attention to medical problems, housing access, and preventive services, such as assessment of and training in necessary skills (e.g., money management, parenting, employment, and other life skills). Cattan and Tilford (2006) suggest that for younger people who are homeless, including young adults, mental health promotion activities that help create a sense of community and empowerment may

be particularly important. Thus, prevention activities at this stage may include encouraging participation in positive community activities (e.g., sports and the arts) and community service.

Intensive care is implemented in a manner that emphasizes clients' participation in defining and managing their own goals. People in intensive care may drop out or return to homelessness and need to be reengaged several times. In some cases, people verbalize this choice; in others, it is evidenced by angry outbursts, disappearance from services, rule violations, or other behaviors. Appropriate responses include respecting personal choices, attempting to reengage, welcoming the person back, and revising treatment and prevention plans when he or she returns. Some people in this phase will accept higher intensity transitional housing models combined with behavioral health services as well as social and medical services. Others will only accept options that provide housing and voluntary participation in supportive services.

It is important in the intensive care phase of homelessness rehabilitation to ensure that people maintain the gains they have made through previous substance abuse and mental health services. Maintaining momentum for recovery and relapse prevention, continued use of new skills, and involvement in community activities can be essential at this point. Staying in touch with mental health, substance abuse, and other resources in the community is critical, even given transportation problems, employment considerations, multiple pressing needs, and financial constraints.

This phase requires behavioral health services that are integrated with other ongoing housing, healthcare, legal, and social services. Close collaboration among all providers is a priority. The case management skills that treatment professionals use are highly applicable to serving these clients.

Transition from intensive care to ongoing rehabilitation

Before individuals move into the ongoing homelessness rehabilitation phase (when they are preparing for optimal social reintegration), it is important to ensure that they have a comprehensive and evolving plan for sustaining the process of recovery, including acquisition of stable housing, gains made in social and other skills, and involvement in community activities. Successful plans also include a realistic long-term plan for relapse and homelessness prevention, development of strong connections to social supports (e.g., family, faith, and recovery communities), stable income and health benefits (e.g., job skills and employment, health insurance, Federal disability benefits, local government cash supports, veterans benefits, food stamps), and meaningful daily activities that complement their recovery plans.

Making the transition from intensive care to the open-ended stage of ongoing rehabilitation takes time. Increased risk of dropout from services (including behavioral health services) because of increased ambivalence is common and can be addressed by providing increased case management services, staff attention, incentives to remain engaged (e.g., paid vocational services contingent on abstinence and positive work behaviors, transportation), and increased relapse prevention efforts.

Some people may attain such improved functioning, coping skills, social support, and financial resources that they can maintain independent, affordable housing with follow-up services to ensure their gains in recovery and other areas of functioning. Others may benefit from 1 to 2 years or more of a supportive recovery and housing environment (e.g.,

Oxford Houses) to develop better coping skills for maintaining recovery and improving social functioning. Still others need weekly contact with a case manager from a multidisciplinary, community-based team to address any threats to housing stability and recovery as they arise. Transportation issues that limit participation in ongoing rehabilitation activities must also be addressed prior to exiting this phase.

Behavioral health counseling and anticipatory collaborative problem-solving for clients in transition to ongoing rehabilitation are particularly important. Helping clients stabilize in recovery, engage and maintain attendance in self-help programs, develop a realistic individualized relapse prevention/recovery promotion program, and begin to develop a healthy lifestyle are also important at this point.

Ongoing rehabilitation

Ongoing rehabilitation is an open-ended phase in which people gradually establish an identity as no longer homeless (McQuistion et al., 2008). This stage includes an active and continuing supportive counseling relationship and continued participation in prevention programs as appropriate (e.g., regular follow-up meetings to address any problems related to housing stability and recovery). In this stage, clients have a contact person in case of a crisis or relapse.

You can play a significant role as the program participant begins to depend less on services and service providers for assistance. Your consistent, ongoing collaborative relationship with clients may be especially beneficial as their self-concept, expectations for the future, self-esteem, and ability to manage life's problems evolve. Your support for the person's continued attendance at 12-Step and other wellness self-management programs and involvement in new community activities is also helpful. You can be a role model for appropriate absinent behavior and help people share with others what they have learned in their transition from homelessness to an interdependent relationship with their environments.

Clinical Interventions and Strategies for Serving People Who Are Homeless

Behavioral health service providers working with people who experience homelessness need special skills. Specific knowledge about homelessness and its effect on recovery and change is important, as is careful assessment and modification of attitudes that affect your work with this population. Understanding the cultural context of clients and having the skills to adapt to a variety of cultures of people who are homeless is very important. The skills you normally use in providing behavioral health services are applicable but may also need to be modified or honed to address the specific needs of people experiencing or facing homelessness.

It is beyond the scope of most behavioral health programs to meet many of the urgent needs of people who are homeless. Inevitably, this means that you—who may be the point of contact or "first door" for a person who is homeless or facing homelessness—must have a working knowledge of resources in the community for these people, not only for housing services, but also for services that address physical health care, financial crises, criminal justice constraints, and dietary needs, among other concerns. Ideally, a behavioral health program will maintain reciprocal alliances with other community resources that allow for efficient case management of persons with complex needs.

Additionally, people who are homeless may have special mental health and substance abuse treatment needs, including special trauma-informed treatment services, specialized

care for co-occurring disorders, services to ensure medication management, and close medical supervision while undergoing detoxification.

If not already integrated into programming, treatment programs must include prevention programs in their alliances, because many of these programs are designed to meet high-priority needs of persons and families who are homeless (e.g., skills development, parenting education, expanding recreational opportunities, community involvement). Larger programs, especially treatment programs, may also have a designated case management staff member who coordinates referrals and ensures that clients follow through on referrals and that services are provided.

This TIP discusses seven activities common to many behavioral health service situations along with special adaptations that are useful in working with people who are homeless:

- Outreach
- Initial screening and evaluation
- Early interventions and stabilization
- Treatment and prevention planning
- Case management
- Client retention and maintenance of continuity of care
- Relapse prevention and recovery management

Some of these areas may be more applicable to some settings than others, but unless you work in a very specialized setting, all will probably be applicable to your current or future work.

Outreach

Outreach plays a crucial role in work with people who are experiencing homelessness. It means making contact with individuals on their terms—where they live—rather than in an agency setting. It involves developing sufficient trust to help people consider receiving services and the benefits they might accrue from them. It may well mean developing rapport with people who, because of their experiences, have no expectation of a positive outcome.

Outreach is particularly relevant to the engagement stage of homelessness rehabilitation. It involves deliberately and methodically cultivating a relationship with the person or family who is homeless. Effective outreach skills include:

- Expressing appreciation for survival skills as strengths and coping mechanisms.
- Understanding substance abuse and/or psychological symptoms from the client's perspective and understanding how those symptoms are interrelated.
- Addressing financial and health benefits as well as food, healthcare, housing, and other immediate needs.
- Expressing optimism that together you can create a plan that meets the person's needs.
- Empowering the client to set goals and create a plan for recovery and growth.

You will probably find that outreach efforts with people experiencing homelessness are more aggressive and proactive than those you use in traditional mental health and substance abuse settings. You may find yourself meeting your clients literally where they are rather than waiting for them to come to you. While taking care to respect people's autonomy, you may be more assertive in engaging people into services. In treatment settings, you may be more assertive in establishing the therapeutic relationship. You may find yourself responding more actively to crises or becoming more involved than you would with most treatment clients or prevention program participants. In effect, the skills of outreach are generic, but how you apply those skills may be different from your traditional role.

Initial Screening and Evaluation

This activity will generally be different for treatment and prevention professionals. Within prevention settings, a first contact with a person who is homeless may differ little from your first contact with other program participants. However, you will wish to pay special attention to constraints on participation (transportation, child care, etc.) and assist participants who are homeless in addressing these issues. Within your zone of comfort, you may also want to inquire as to other services that your program participant is receiving and suggest community resources where additional services may be accessed.

Within treatment settings, a first contact with a person who is homeless or facing homelessness will ordinarily involve initial observations and, potentially, decisions about care. For instance, although a prospective client may not be forthcoming with information, it may fall to you to evaluate whether the individual is in immediate danger with consequences to health or safety as a result of his or her life situation. You might be in the position of having to determine whether the client needs immediate care as a result of drug use or mental illness or to evaluate his or her ability to make decisions about care. Frequently, it will be necessary to determine which other team members or program staff persons might be helpful in determining urgent client needs (e.g., primary care provider, housing specialist, other mental health professional).

People who are homeless typically engage gradually with services as trust is established. As opposed to techniques in more traditional settings (whether focused on treatment or prevention), gathering information may take more time and be ongoing; new information may surface as the client stays connected. To understand the client's level of functioning and identify appropriate services, screening and evaluation should gather information about:

- Substance use and/or mental disorders, including:
  - Evidence of a substance use disorder, which can include quantity and frequency of use, compulsive use, craving, and problems related to drug use.
  - The effect of specific symptoms (e.g., paranoid thinking, undue grandiosity, constraints resulting from depression) on a client's ability to seek and accept help with housing and other services.
  - Problematic substance use, symptoms of mental disorders, and client readiness for changing substance use behaviors and other areas of social functioning; specific screening instruments can be used to determine each of these.
  - Screening for the presence of a disorder (positive screens should be referred for further assessment and formal diagnosis).
  - The possibility of co-occurring mental and substance use disorders and the implications of co-occurring disorders for immediate and extended treatment and recovery.
- Current and past exposure to trauma and related safety issues.
- Primary care records, history of medical conditions and hospitalizations, list of previous and current medications, and the current need for medical and dental care, including risk of and treatment for HIV/AIDS and other communicable diseases.
- Onset and course of homelessness and how it relates to the course of other symptoms.
- Current skills and ability to maintain stable housing.
- Current and/or pressing criminal justice issues, including outstanding warrants that

might lead to incarceration; probation and parole status; and current behaviors that, if discovered, might lead to arrest.
- Social functioning in terms of social supports, literacy, education, job skills, employment, and income, as well as:
  - The client's family (as he or she defines it) and other social supports that the client wants to incorporate into the plan for recovery.
  - Immediate stressors (e.g., shelter living, housing instability, lack of money, debt, legal issues).
- Client interest in prevention-related activities, such as life skills development, stress and anger management, anticipatory guidance for youth, parenting programs, recreational or volunteer activities, and cultural enrichment programs. Having a directory of such prevention resources in your community will be a useful adjunct to other service directories you use in your work.

Screening, brief intervention, and referral to treatment

SAMHSA has endorsed the use of SBIRT, which integrates initial screening with brief interventions or referral to treatment in some settings with people who may have problems with substance use—including clients with substance use disorders and co-occurring mental disorders. SBIRT is particularly useful with individuals who are homeless in that it requires relatively little time (roughly 5 minutes to screen a patient and 10 minutes to provide a brief intervention) and can prevent the need for further, more intensive services later on (Bernstein et al., 2009).

In 2009, the National Institute on Drug Abuse released an Internet-based, interactive tool for screening and brief intervention to address use of illicit substances. Research supports the efficacy of SBIRT in reducing heavy use of alcohol and illicit drug use across a range of settings and clients. One evaluation of SAMHSA's SBIRT service program found that SBIRT interventions had a positive impact on homelessness as well, with significantly fewer patients reporting lack of housing 6 months after the intervention than had reported it at baseline (Madras et al., 2009).

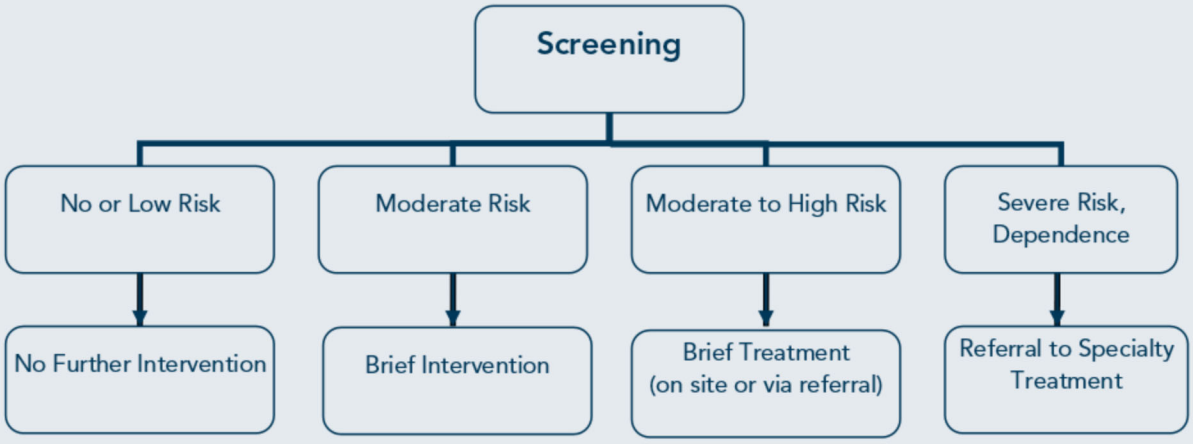
SAMHSA's SBIRT model provides for early intervention and treatment services on a continuum of substance use. Beyond providing for substance abuse treatment, SBIRT also targets nondependent substance use problems and provides effective strategies for early intervention before the need develops for more extensive or specialized treatment. See SAMHSA's planned Technical Assistance Publication, *Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment*, for more information (SAMHSA, planned g).

Early Interventions and Stabilization

As behavioral health service providers further develop and maintain trusting relationships, they engage in intensive early intervention and stabilization while addressing urgent environmental needs (such as health or criminal justice issues) and managing acute substance abuse and mental health symptoms. In both treatment and prevention, this activity involves constructing a treatment and/or prevention plan that is person centered, adhering to an individual's goals. Some people who are homeless will need detoxification as part of a stabilization process. Others may need brief hospitalization to stabilize acute symptoms. Stabilizing is a process of beginning to restore physical health and feelings of safety, to relieve emotional turmoil, and to get a sense of future goals and needs.

Stabilization is a prerequisite for beginning an ongoing recovery program. Yet, for some peo-

How Does SBIRT Work?



Screening (S) is a process of identifying clients with possible substance abuse problems and determining the appropriate course of future action for these individuals. The screening process does not identify exactly what kind of problem the person might have or how serious it might be; it simply determines whether a problem exists and, if so, whether further assessment is needed.

Brief intervention (BI) is appropriate for clients identified through screening to be at moderate risk for substance use problems. BI can be provided through a single session or multiple sessions of motivational interventions. These interventions focus on increasing a client's insight into and awareness about substance use and behavioral change.

Brief treatment (BT), also called brief intensive intervention, is a specialty outpatient treatment modality—a systematic, focused process that relies on assessment, client engagement, and implementation of change strategies. The treatment consists of assessment and a limited number (typically 6 to 20) of evidence-based, highly focused, and structured clinical sessions (e.g., solution-focused therapy, cognitive–behavioral therapy). Clients may receive BT on site but more commonly are referred to an outside program or another component of a medical system.

Clients identified as needing BT or more intensive treatment are referred to specialty substance abuse treatment (**referral to treatment** [RT]), the primary goals of which are to identify an appropriate treatment program and to facilitate the individual's engagement. RT requires a proactive, collaborative effort between SBIRT providers and those providing specialty treatment to ensure that, once referred, the client accesses and engages in the appropriate level of care.

Source: SAMHSA, planned g.

ple—particularly those who have been living in ambiguity, chaos, or from crisis to crisis—stabilization can be uncomfortable. Some might describe their experience as "waiting for the other shoe to drop." Others may have a well-developed ability to "look good" despite physical, emotional, interpersonal, and environmental instability. It is important for you to assess carefully the rate and extent to which a person has actually begun to stabilize; you must resist the temptation to push ahead before stabilization is established. This accentuates how the activities of stabilization may often challenge engagement, in that careful and active worker–client collaboration is required.

Treatment and Prevention Planning

Treatment and prevention planning needs to be person-centered, addressing the client's goals and using agreed-upon strategies. Planning should include decisions about:

- Which services the person needs and wants.
- Where the services will be provided.
- Who will share responsibility with the individual for monitoring progress.
- How services will be coordinated and reimbursed.

Developing treatment and prevention plans for clients with complex needs is, at best, difficult. Services have to be prioritized and plans made based on outcomes that have not yet been achieved. Both treatment and prevention are likely to involve multiple programs, each with its own goals and priorities, rules, and restrictions, and with different levels of involvement with the client or program participant. For instance, some services require a one-time visit (such as obtaining identification or screening for substance-related and mental health issues), whereas others—such as management of chronic health conditions—may be ongoing. Given this degree of complexity, treatment plans should include:

- Specific biopsychosocial goals relevant to the individual and his or her living situation.
- Projected timeframes for accomplishing these goals.
- Appropriate treatment and prevention approaches.
- Housing and services the client will need during service delivery.
- Follow-up activities during ongoing rehabilitation.

Some services may have priority over others by virtue of immediacy of need or other constraints. For many people who are homeless, life stabilization and safe housing are requisites for approaching and establishing recovery from substance abuse or mental illness. For others, achieving some treatment goals (such as abstinence) may diminish the intensity or importance of other problems. Most important, treatment and prevention planning needs to consider the whole person and to prioritize clients' immediate and longer-term goals. Planning should consider the environment in which clients live, differentiate between the problems that can be resolved and those that can only be lessened, and set priorities for services.

Case Management

Case management, which is often assertive in the beginning of care for people in homelessness rehabilitation, is essential in addressing clients' manifold needs and preventing clients from becoming lost in the maze of community services. The job of case management will generally fall to a counselor in a treatment agency, but there is no reason why a properly trained preventionist cannot serve as a case manager. Although most behavioral health counselors are well trained in case management processes and techniques, clients who are homeless have unique needs and may require assistance with such tasks as arranging transportation, obtaining appropriate clothing for interviews, ensuring follow-through on referrals, understanding the instructions provided by other agencies, and assembling appropriate information and credentials needed by other community programs. Particularly in work with people who are homeless, case management services need to begin when the client enters the service system so that needs are anticipated, clients are not overwhelmed with numerous referrals at once, and you and your clients have time to prepare for upcoming referrals.

Preventive services using case management methods

Although traditionally associated with health, mental health, or substance abuse treatment services, case management extends to preventive services as well. Indeed, the same concerns that motivate case management in treatment services (e.g., matching services to needs, locating appropriate providers, supporting participation in and compliance with collaborative treatment planning, assisting with logistics such as transportation and child care, monitoring attendance and progress) apply as much to preventive services.

The same person may serve as a treatment and prevention case manager, or the prevention case management function may be fulfilled by a prevention professional collaborating with the treatment case manager. In either case, the goal is to integrate treatment and prevention services to meet the unique needs and personal goals of the service recipient.

This TIP emphasizes that people who are homeless or at risk of homelessness can benefit from a variety of preventive services, especially clinical preventive services (i.e., selective and indicated prevention; see Exhibit 1-1). The TIP has discussed a variety of preventive services, including screening and brief or early intervention for emerging substance use or mental disorders, skill building (e.g., parenting skills, coping skills, anger management), strengthening families, relaxation training, exercise, recreation programs, and community involvement. These are illustrated in Vignettes 4 (Troy) and 6 (Mikki) in Part 1, Chapter 2. Such services may be offered by local governments, schools and community colleges, freestanding prevention agencies, social service agencies, primary care providers, organizations that serve aging individuals, community clinics, Boys & Girls Clubs, YMCAs, YWCAs, fraternal organizations, congregations, community coalitions, and so on. Not all communities offer all these services. Prevention case managers should develop a comprehensive prevention directory for use in matching client needs to available services.

The principles and procedures presented in this chapter apply to prevention-related case management as much as to treatment-related case management. The only difference is that the prevention case manager will likely need to access a wider variety of community agencies to meet preventive service needs.

Retaining Clients in Treatment and Maintaining Continuity of Care

For clients who have been living with chronic crises of housing, health care, drug use, criminal justice constraints, financial needs, and perhaps other issues, providing comprehensive, integrated care can seem an impossible task. As a result, it becomes important to keep treatment and prevention goals realistic and achievable, relatively short term (although you and the client may have long-term goals in mind), and measurable. Specific strategies to improve retention may be desirable, such as rewards for achieving and maintaining drug abstinence or consistent participation in treatment or prevention activities.

Defining a process for the setting of goals can be beneficial. You should collaborate with clients to set goals in accordance with their priorities. Targeted goal management will allow you to work with clients to assess current and evolving needs for financial benefits and health insurance; substance abuse, psychological, and medical treatment and prevention services; housing resources; access to transportation; employment and education; social supports; assistance with legal problems; and recreational activities.

As people identify their most important, pressing goals, collaboratively identify one activity related to each goal area that:

- Is specific (e.g., number of weekly negative urine samples screened, groups attended, parenting sessions completed, volunteer opportunities identified, or job applications completed).
- Can be completed successfully in a given timeframe.
- Can be verified objectively via receipts, agency reports, worksheets, or the like.
- Is tailored to the client's individual level of psychosocial functioning and personal and social resources to increase the likelihood of successful completion.

Small successes and progress toward personally meaningful goals while maintaining accountability and autonomy build client self-esteem and confidence. Your relationship with the people you serve is strengthened through collaborative decisionmaking about activities to be accomplished and reinforcing the individual's completion of activities. In traditional treatment programs, reinforcement for completing activities includes social recognition and sponsor status in mutual support groups, take-home privileges, early dosing windows in methadone maintenance programs, and vouchers for self-care items and food. In prevention programs, reinforcement may take the form of social recognition, opportunities for training, or attendance at conferences.

Relapse Prevention and Recovery Management

Clients with mental illnesses, substance use disorders, cognitive impairment, and/or family histories of substance use and mental disorders are at higher risk for relapse and subsequent loss of housing (see the planned TIP, *Recovery in Behavioral Health Services* [SAMHSA, planned e]). As individuals move into the clinical stage of ongoing rehabilitation, a variety of evidence-based and best practices interventions are available to support personal recovery, including relapse prevention and wellness self-management.

Wellness self-management, also termed illness self-management, is a manualized, evidence-based, time-limited group technique that helps teach skills of maintaining and enhancing health and wellness (Mueser et al., 2006). Interventions are typically delivered through a series of classroomlike group sessions that capitalize on cognitive–behavioral techniques, each focusing on a wellness topic, such as medication compliance, diet, or stress management. Simultaneously, mental health and substance use issues undergo continuing treatment, along with housing supports. Supportive housing that accepts and addresses relapse or recurrence of psychiatric symptoms aids this. Coping skills training, employment and educational assistance, and the encouragement of establishing social connectedness through participating in other community institutions (e.g., faith-based organizations, senior centers, community volunteer groups, recreational groups), as well as recovering family ties, help maintain the personal recovery process (Marlatt & Donovan, 2005).

Evidence-Based Practices in Homelessness Rehabilitation

Exhibit 1-6 presents promising and evidence-based practices that support people who are homeless while they move through the stages of rehabilitation and establish stable housing and long-term recovery. You may already use these practices in the behavioral health treatment settings in which you work.

Several evidence-based practices have been evaluated specifically with homeless populations, including ACT, critical time intervention (CTI), motivational interviewing (MI), contingency management, cognitive–behavioral

Exhibit 1-6: Promising and Evidence-Based Practices by Rehabilitation Stage

Treatment Approach		Engagement	Transition	Intensive Care	Transition	Ongoing Rehabilitation
Incentives (food, transportation, benefits)		X	X	X	X	
Primary medical care		X	X	X	X	X
Motivational interviewing		X	X	X	X	X
Clinical preventive services	Indicated (e.g., screening, brief intervention)		X	X	X	X
	Selective (e.g., skills development, anger management, anticipatory guidance, parenting programs)		X	X	X	X
	Universal prevention programs (e.g., workplace programs, recreation programs, volunteerism)	X	X	X	X	X
Integrated treatment for CODs		X	X	X	X	X
Peer support		X	X	X	X	X
Family and social support		X	X	X	X	X
Intensive case management		X	X	X	X	
Critical time intervention			X		X	
Contingency management			X	X	X	
Assertive community treatment		X	X	X		
Illness self-management					X	X
Medication			X	X	X	X
Cognitive–behavioral interventions				X	X	X
Relapse prevention				X	X	X
Supportive housing		X	X	X	X	X
Supportive employment (e.g., the International Center for Clubhouse Development model)					X	X

interventions, supportive housing, and supportive employment. ACT is a widely used treatment method adapted from services for people with chronic mental illness for work with people who are homelessness. Numerous studies (e.g., King et al., 2009; Nelson, Aubry, & Lafrance, 2007) have shown that the intensive services provided by ACT teams increase treatment adherence, reduce days of hospitalization, and increase housing stability. Teams composed of mental health professionals provide a wide variety of services, including case management, mental health services, crisis intervention, treatment, education, and employment support. ACT services are available around the clock to respond to the client's immediate needs. ACT has been widely implemented in a number of countries, including the United States. For more information on ACT, visit the ACT Association Web site (http://www.actassociation.org).

CTI is a time-limited adaptation of intensive case management to bring problem-solving resources, community advocacy, and motivational enhancement to clients who are homeless. It is particularly useful in work with clients who are in transition, such as those entering homeless shelters from prison, and in the development of continuity of care for

people with CODs who are leaving shelters for other community housing resources (Draine & Herman, 2007; Herman, Conover, Felix, Nakagawa, & Mills, 2007; Jones et al., 2003). New York Presbyterian Hospital and Columbia University (2011) developed *The Critical Time Intervention Training Manual,* which describes the phases of the 9-month program of care in CTI as follows:

- Phase One—Transition to Community. A treatment plan is made; clients are linked to appropriate community resources.
- Phase Two—Try Out. Linkages in the system are tested; the treatment plan is formalized, adjusted, and implemented.
- Phase Three—Transfer of Care. Long-term community linkages are monitored and long-term goals are established; work toward them is begun.

Contingency management uses tangible rewards for housing, work training, and work opportunities and can provide direct monetary reinforcement (e.g., gift cards) for accomplishing clearly defined weekly rehabilitation goals. These procedures have been studied intensively in a community setting in Birmingham, AL, in a series of four randomized, controlled trials that showed significant improvement in sustained abstinence, housing stability, and stable employment (Milby et al., 1996, 2000, 2005, 2008).

Cognitive–behavioral interventions have shown clear treatment advantages and sustained superior outcomes for abstinence from 6 to 12 months and from 12 to 18 months after follow-up compared with contingency management alone in a delayed treatment effect. Additional cognitive–behavioral interventions were added to and compared with contingency management alone (Milby et al., 2008).

MI is a client engagement, motivational enhancement, and counseling process that has been widely used in mental health and substance abuse treatment settings and has been adapted for the needs of clients in homelessness rehabilitation. It is particularly efficacious in work with clients who are homeless, abuse substances, and are entering sober housing (Fisk, Sells, & Rowe, 2007). Many standard MI techniques and protocols for enhancing commitment to treatment and reducing resistance are applicable to clients experiencing homelessness. For more information on MI protocols, see TIP 35 (CSAT, 1999b).

Supportive housing can improve sustained abstinence, stable housing, and employment (Milby, Schumacher, Wallace, Freedman, & Vuchinich, 2005), and it can greatly improve housing stability for clients with serious mental illness who are homeless (Tsemberis, Gulcur, & Nakae, 2004).

Supportive employment assists clients in accessing, obtaining, and maintaining employment as a primary method to prevent or end homelessness. Recognizing work as a priority in preventing or ending homelessness, Shaheen and Rio (2007) note that early treatment and rehabilitation efforts often focus more on housing and supportive services and highlight the value of assisting clients in obtaining employment and/or education early in rehabilitation. They suggest that employment helps clients who are experiencing homelessness develop trust, motivation, and hope. Supportive employment not only helps people find jobs; it also helps them achieve continued employment by teaching them skills such as problem-solving, managing interpersonal conflicts, developing appropriate work-related behaviors, and managing money wisely.

Your knowledge and skills in working with clients who have mental and substance use disorders may be particularly important in helping them maintain abstinence, regulate symptoms, maintain motivation, and

strengthen the interpersonal skills that are necessary to maintain employment and pursue education. Many individuals who have not been employed for months or years—clients who are just leaving prison or are chronically mentally ill—may first need a supervised work environment to develop or improve these skills. The VA hospital system has used a variation of supportive employment called individual placement and support (IPS). IPS focuses on rapid placement in jobs of the clients' choosing, competitive employment, ongoing and time-unlimited support, integrated vocational assistance and clinical care, and openness to all who want to work, regardless of clinical status or work experience (Rosenheck & Mares, 2007).

There are dozens of universal, selective, and indicated evidence-based prevention programs applicable to populations of people who are homeless, but few have been specifically tested with these populations. SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) lists two evidence-based prevention programs for youth that address substance abuse and mental health outcomes.

The Curriculum-Based Support Group (CBSG) Program (Arocena, 2006) is a support group intervention designed to increase resiliency and reduce risk factors among children and youth ages 4 through 15 who are identified by school counselors and faculty as being at elevated risk for early substance use and future delinquency and violence (e.g., they are living in adverse family situations, displaying observable gaps in coping and social skills, or displaying early indicators of antisocial attitudes and behaviors). Based on cognitive–behavioral and competence-enhancement models of prevention, the CBSG Program teaches essential life skills and offers emotional support to help children and youth cope with difficult family situations; resist peer pressure; set and achieve goals; refuse alcohol, tobacco, and drugs; and reduce antisocial attitudes and rebellious behavior.

Lions Quest Skills for Adolescence is a multicomponent, comprehensive life skills education program designed for schoolwide and classroom implementation in grades 6 through 8 (ages 10–14). The goals of the Lions Quest program are to help young people develop positive commitments to their families, schools, peers, and communities and to encourage healthy, drug-free lives. (See SAMHSA's NREPP for further information at http://nrepp.samhsa.gov.)

Say it Straight (Englander-Golden et al., 1996) is a communication training program that helps students and adults develop empowering communication skills and behaviors and increase self-awareness, self-efficacy, and personal and social responsibility. In turn, the program reduces risky or destructive behaviors (e.g., substance use, eating disorders, bullying, violence, precocious sexual behavior, behaviors that can result in HIV infection).

One area of mental health promotion/mental illness prevention that has been addressed in some literature is suicide prevention. People who are homeless have high rates of suicidal ideation and suicide attempts. Childhood homelessness, being homeless for 6 months or more, and substance use disorders in adults ages 55 and older are all associated with greater rates of suicidality (Prigerson, Desai, Mares, & Rosenheck, 2003). More information on suicide prevention for clients in substance abuse treatment can be found in TIP 50, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009a).

Additionally, a variety of evidence-based practices noted in NREPP, although not tested specifically with populations of people who are homeless, have significant implications for

The Clubhouse Model of Transitional Employment

NREPP lists the International Center for Clubhouse Development's (ICCD's) clubhouse model as an evidence-based program. A clubhouse is a day program, often run at a community center, that supports people recovering from mental illness by helping them rejoin the job force and fostering stronger friendships, family relationships, and educational aspirations. Clubhouses are built on:

- *A work-ordered day.* The daily activity of a clubhouse is organized around a structured system known as the work-ordered day. The work-ordered day includes an 8-hour period that parallels typical business hours. During this period, members and staff work together to perform important tasks in their communities. There are no clinical therapies or treatment-oriented programs in the clubhouse; members volunteer to participate as they feel ready and according to their individual interests.
- *Employment programs.* Clubhouses provide members with opportunities to return to paid employment in integrated work settings. These opportunities include transitional employment—a highly structured means for gaining work in local business and industry. Members receive part-time placements (15–20 hours per week) along with onsite and offsite support from clubhouse staff and members. Placements generally last 6 to 9 months, after which members can seek another transitional placement or move on to independent employment. Transitional employment allows mentally ill individuals to gain the skills and confidence necessary for employment while they hold a real-world job.
- *Evening, weekend, and holiday activities.* Clubhouses provide both structured and unstructured social/recreational programming outside the work-ordered day.
- *Community support.* People with mental illness often require a variety of social and medical services. Through the work-ordered day, members receive help accessing the best quality services in their community, acquiring and keeping affordable and dignified housing, receiving psychiatric and medical services, getting government disability benefits, and so forth.
- *Outreach.* Clubhouse staff maintain contact with all active members. If a member is hospitalized or does not attend the clubhouse, a telephone call or visit serves to remind that member that he or she is missed, welcomed, and needed at the clubhouse.
- *Education.* Clubhouses offer educational opportunities for members to complete or start certificate and degree programs at academic and adult education institutions. Members and staff also provide educational opportunities within the clubhouse, particularly in areas related to literacy.
- *Housing.* A clubhouse helps members access safe, decent, dignified housing. If there is none available, the clubhouse seeks funding and creates its own housing program.
- *Decisionmaking and governance.* Members and staff meet in open forums to discuss policy issues and future planning. An independent board oversees management, fundraising, public relations, and the development of employment opportunities for members.

The ICCD Web site (http://iccd.org/) offers a directory of clubhouses and more information on this transitional employment model. TIP 38, *Integrating Substance Abuse Treatment and Vocational Services*, covers employment services and can help you select employment support models suitable for clients who are homeless and have behavioral health issues (CSAT, 2000a). SAMHSA's *Supported Employment Evidence-Based Practices (EBP) KIT* (SAMHSA, 2009) provides practice principles for supported employment, an approach to vocational rehabilitation for people with serious mental illness. It promotes the belief that everyone with SMI is capable of working competitively in the community. The KIT is available for free at SAMHSA's Publications Ordering Web page (http://store.samhsa.gov).

Source: International Center for Clubhouse Development, 2009. Adapted with permission. See also Schonebaum, Boyd, & Dudek, 2006; Macias, Rodican, Hargreaves, Jones, Barreira, & Wang, 2006.

work with this population. Three examples of tested programs for trauma treatment include Seeking Safety, Trauma Recovery and Empowerment Model (TREM), and a modification of TREM, The Boston Consortium Model: Trauma-Informed Substance Abuse Treatment for Women. All of these programs use cognitive–behavioral and psychoeducational methods to teach problem-solving, coping skills, and affect regulation strategies to individuals who have experienced significant trauma. A program that is particularly relevant to people who are homeless and have co-occurring substance use and mental disorders is Modified Therapeutic Community for Persons With Co-Occurring Disorders, a long-term residential program with the structure and processes of a traditional therapeutic community but with adaptations for individuals with co-occurring disorders. The program can be flexibly applied in both correctional and community settings and includes components on mental health and substance abuse treatment. For more information on these and other evidence-based programs, refer to the NREPP Web site (http://nrepp.samhsa.gov/).

Special Issues in Service Delivery

People with substance use and/or mental disorders who are homeless have a variety of specific needs and considerations in treatment and prevention programs. These needs tend to fall into three major categories:

- Specific client needs
- Family services to reduce the risk of intergenerational problems
- Cultural competence

Specific Client Needs

It is unrealistic to expect that people who are experiencing homelessness will be able to maintain housing if their social and health needs are not met. It is also much more difficult for individuals with substance use and mental disorders to manage their symptoms when these basic needs are not met. Some of the most pressing issues of people who are homeless include:

- Addressing acute and chronic medical conditions (e.g., diabetes, HIV infection, heart and respiratory conditions, and the like, as well as drug detoxification and medical stabilization of mental illnesses).
- Having untreated or inadequately treated disabilities, such as hearing and/or vision impairment, lack of balance, or mobility impairments.
- Recognizing cognitive problems, such as memory deficits, poor attention, and concentration.
- Making the transition from jail or prison to the "free world," which includes adapting survival skills that were functional in prison but are counterproductive outside the criminal justice system.
- Making the transition from inpatient hospitalization, where people are free from responsibility for their care, to having to assume full accountability for their care and their behavior.
- Dealing with a history of trauma when sudden or unexpected events may trigger flashbacks or other responses that are perceived as inappropriate and when symptoms of psychological trauma mimic, exaggerate, or obscure the symptoms of other mental and substance use disorders.

Family Services To Reduce the Risk of Intergenerational Problems

Integration of prevention and treatment services for families who are homeless is critical. Family programs involving parents and their children have been a mainstay of universal, selective, and indicated prevention programs

for at least 3 decades. Examples include parent participation (e.g., homework assignments) in school-based programs (universal), home-visit programs for high-risk families (selective), and intensive parent–child interventions when one or both parents are undergoing substance abuse treatment (indicated). All of these programs—particularly those categorized as indicated—are appropriate for families who are homeless in which the parents receive substance abuse or mental illness treatment.

NREPP (http://nrepp.samhsa.gov) lists over 50 family programs that may be relevant to working with families who are homeless. A few examples include:

- The Strengthening Families Program: This is a family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children 3–16 years old.
- The Strengthening Families Program for Parents and Youth 10–14: This family skills training intervention is designed to enhance school success and reduce youth substance use and aggression among 10- to 14-year-olds.
- The Clinician-Based Cognitive Psychoeducational Intervention: Intended for families with parents who have a significant mood disorder, this intervention is designed to provide information about mood disorders to parents, equip them with skills they need to communicate this information to their children, and open a dialog in families about the effects of parental depression.
- DARE To Be You: This multilevel prevention program is intended for high-risk families with children 2–5 years old. Program objectives focus on children's developmental attainments and aspects of parenting that contribute to youth resilience to later substance abuse, including parental self-efficacy, effective child rearing, social support, and problem-solving skills.
- Familias Unidas: A family-based intervention for Hispanic families with children ages 12 to 17. The program is designed to prevent conduct disorders; use of illicit drugs, alcohol, and cigarettes; and risky sexual behaviors by improving family functioning.

Cultural Competence

Race, ethnicity, and culture influence how people express problems, seek help, and accept services. Your cultural background and that of your clients can influence how you present services and how acceptable they are to clients. Staff members should reflect the diversity of the population, work in teams that incorporate diversity, and engage in team discussions about the influence of cultural factors on engagement and retention, risk and protective factors, and resiliency (Rowe, Hoge, & Fisk, 1996). It may be important to include service providers on your team who have experienced homelessness themselves and understand that homelessness itself can be part of a subculture with its own expectations, behaviors, and patterns of communication; understanding this culture is essential to effective work with individuals and families who are homeless.

Culturally competent service providers understand that people sometimes reject services because of cultural norms and/or past negative experiences with the service system. For example, your organization may find that many clients who are at risk of homelessness live with family members who will not come to your organization for services. A culturally responsive service strategy may involve a service provider of the same cultural background providing services where the client lives. You can act as a consultant, offering psychoeducation and skills development to address

individuals' issues in a manner that is acceptable to them (Connery & Brekke, 1999).

Culturally competent counselors are also mindful of the client's linguistic requirements and the availability of interpreters. You should be flexible in designing a treatment plan to meet client needs, and, when appropriate, you should draw upon the institutions and resources of your client's cultural community. Treatment providers need to plan for the provision of linguistically appropriate services beginning with actively recruiting bicultural and bilingual clinical staff, establishing translation services and contracts, and developing treatment materials prior to client contact. Even though you cannot anticipate the language needs of all potential clients, you *can* develop a list of available resources and program procedures that can be followed when language needs fall outside the treatment program's typical client demographics.

Women often have unique experiences and challenges different from the male majorities usually found in substance abuse treatment. They often find or take few opportunities to talk in male-dominated groups about physical or sexual abuse perpetrated by the men in their lives, perceived barriers to restoring child custody, and other women's issues. Absence of opportunities to discuss gender-related problems usually precludes the development of a comprehensive rehabilitation plan to address them (CSAT, 2009d).

People who are lesbian, gay, bisexual, or transgendered may face different barriers to services. People who are transgendered may need special consideration of options and advocacy prior to placement in shelters, treatment centers, prevention programs, and housing.

For more information on culturally competent behavioral health treatment, see the planned TIPs, *Improving Cultural Competence* (SAMHSA, planned c) and *Behavioral Health Services for American Indians and Alaska Natives* (SAMHSA, planned a), as well as *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals* (CSAT, 2001).

Community Housing Services for People Who Are Homeless

Unless you work in a setting specifically designed to serve people who are homeless, you are probably not acquainted with the variety of homelessness services available in your community. Services can vary widely from one community to another based on community needs and program goals. You may also not be aware of abstinence or other specific requirements among different program and housing options. Housing services also exist for special populations that might be important in your work, such as veterans or people who live in rural areas. Additionally, the services clients need will vary by the type of homelessness they are experiencing.

In general, housing services can be divided into four main categories.

Emergency shelters provide brief-stay, overnight accommodation to people who have no safe place to stay for a short period of time. Often, people cannot enter the shelter until the late afternoon and must leave by a specific time the next morning. Most allow for storage of personal possessions during the day while the individual has to be out of the shelter; some require that all possessions be taken by the occupant when they leave each day. Most shelters offer assistance with food and other emergency needs, but given their short-term focus, do not provide ongoing services for residents.

Temporary housing can be provided in a variety of settings, including shelter settings (such as a shelter specifically for persons affected by domestic violence), multiple-occupancy dwellings, hotels and single-room occupancy (SRO) settings, small clustered apartments, or apartments in the community. Temporary housing is often a resource for families and individuals in crisis who need immediate housing help and assistance with social service, health, mental health, substance use, financial, legal/criminal justice, and other needs. Temporary housing services typically provide outreach and engagement, case management, referral, and follow-up services to mitigate or resolve crises. Temporary housing services are generally limited to 2 or 3 months' duration. After stabilization, individuals and families may move to either transitional or permanent supportive housing.

Transitional housing is useful for individuals who have no permanent place to live and are making a transition from a location where they have been temporarily housed (temporary housing, a substance abuse or mental health treatment facility, a criminal justice setting, etc.) to housing that supports their transition to a more permanent setting. Transitional housing is normally provided for periods of a few months to 2 or 3 years and is accompanied by a variety of resources (social services, health care, employment assistance, mental health and substance abuse treatment, case management, and other services). The use of transitional housing supports for people who have been in substance abuse and/or mental health treatment to smooth reentry into the community is discussed in Part 1, Chapter 2, of this TIP (see the vignette about Sammy). Transitional housing and accompanying supportive services are funded by a variety of resources.

Permanent supportive housing combines a long-term commitment to affordable housing with supportive services to allow individuals and families to live more productive and stable lives; it is a primary thrust of SAMHSA's (along with other Federal agencies') efforts to address the needs of people with disabilities. Typically, permanent supportive housing provides homes for individuals and families who otherwise would be living with the constant threat of homelessness and would lack the supportive social and health services (such as primary health care, mental health treatment, employment, and economic and other resources) necessary to adequately cope in the community. There are no requirements that individuals in permanent supportive housing obtain mental health or substance abuse treatment, and there are no requirements about abstinence from alcohol and/or drugs as a condition for participation in the program. Supportive housing can, however, be coupled with such social services as job training, life skills training, and alcohol, drug abuse, and mental health treatment.

Case management is a key element in helping individuals and families in permanent supportive housing obtain the care they need. Permanent supportive housing can be an apartment or SRO in a building that houses individuals who were formerly homeless, special-needs housing in the same building with generally affordable housing, a rent-subsidized apartment in the open housing market, designated units within privately owned buildings, or individual single-family homes.

Examples of populations served by permanent supportive housing are adolescents, the elderly, persons with serious mental illness, people who are developmentally disabled, and people moving out of transitional or temporary housing who still lack the resources to live in the community without housing assistance. Permanent supportive housing has been shown to be economically viable by creating safe and

stable environments in which individuals and families can regain employment, reduce social service and healthcare costs, and reduce costs related to dependence on more expensive housing options. As with transitional housing, permanent supportive housing is supported by HUD, SAMHSA, other Federal resources, State and community resources, and direct payment from those receiving services.

SAMHSA's Homelessness Resource Center (http://homeless.samhsa.gov/) offers resources on community housing services for individuals and families who are homeless or threatened with homelessness. Their efforts include the *Permanent Supportive Housing Evidence-Based Practices (EBP) KIT* (SAMHSA, 2010), a series of eight booklets on developing permanent supportive housing programs using evidence-based practices.

What the Behavioral Health Service Provider Should Know

Your community may offer a variety of housing options to behavioral health clients who are homeless or are at high risk for homelessness. Some of these options are for emergencies only or are short term, whereas others are ongoing. Some have special restrictions, such as serving only persons with a major mental illness or requiring participation in programs to build employment, money management, and daily living skills. Some programs that primarily serve clients with substance use disorders have rules about drug use either in the residence or while a client is in the program. However, the permanent supportive housing approach, a major focus of Federal housing assistance today, does not mandate mental health, substance abuse, or other care or social services as a condition of participation.

One of your jobs is to become familiar with the resources in your community. You will want to build linkages with these organizations and with their staff members to learn what range of services they provide. This will allow you to recommend particular clients to these organizations in accordance with their specific needs. What are the requirements for accessing their services? What types of reimbursement do they accept? You may be aware of gaps in the services available in your community. Collaborative efforts can, in some cases, help obtain funding, staff, and facilities to fill these gaps. Part 2 of this TIP discusses "bottom-up planning," in which treatment staff identify a service need and programs evolve in response to it. Bottom-up planning should always involve program administration, direct service personnel, clients, and other community resources.

Knowing how to assess your clients' needs is also part of your job. Do they need substance abuse and/or mental health services? Are they ready to accept such services? From what types of medical services and financial help would they benefit? Are they self-sufficient? Do family members need prevention services? Do they require special services to address physical or other disabilities? Are their housing needs chronic and long term or transitional and short term?

Along with these questions, you will want to consider the issue of how best to present a program's goals and rules to clients so as to encourage them to take advantage of community resources. They may need to accept restrictions on their behavior in exchange for shelter. Some negotiation may be necessary to help the client see the advantages of receiving services while consenting to a program's boundaries.

Housing Services for Individuals With Substance Use and/or Mental Disorders

Housing services for people with a substance use disorder and/or a mental illness can be divided into two broad categories: (1) housing specifically provided for clients in early and ongoing recovery from substance use and mental disorders, and (2) housing that offers a safe place to live, a variety of options for homelessness rehabilitation, and other social, health, and behavioral health services. Sometimes, these programs will offer behavioral health treatment and prevention services primarily directed toward the precontemplation and contemplation phases of treatment.

Some communities may offer homelessness and behavioral health treatment services that overlap with these two housing options. Additionally, other shelter or housing options in your community may simply offer temporary housing with no additional social, physical health, or behavioral health services. Because most communities have few, if any, prevention services specifically designed for persons who are homeless, training for prevention workers in the special needs of homeless populations may broaden the range of preventive interventions available to these populations.

Clearly, there is no "one size fits all" accommodation for the diverse population of people with substance use disorders and/or mental illness who are also faced with homelessness. For example, people who are in crisis and transitionally homeless need different services from those who are chronically homeless. Programs for persons with mental or substance use disorders may need to work in close coordination with homelessness programs, especially in early recovery.

Housing services focused on supporting recovery from substance abuse and mental illness

In your work, you will encounter individuals who either are homeless when they enter your program or become homeless during program participation. Some people who are homeless enter programs, especially treatment programs, because they perceive that they have no other place to go. Others—including persons coming from the criminal justice system—may have had stable housing (jail or prison) but have not considered where to live after being released. Some lose their jobs before or during program participation and are left with no housing options. Others may have family members who refuse to allow them to return until they have achieved substantial sobriety, significant stabilization of their psychological symptoms, or significant improvement in interpersonal skills. In any case, homelessness or the threat of it represents a substantial crisis that destabilizes people and challenges their ability to maintain recovery and other gains.

Homelessness also represents a significant case management problem for mental health and substance abuse treatment staff members who are concerned with finding housing resources. Some considerations that have to be addressed include limited resources for housing people in early recovery from substance abuse and/or mental illness in the community, the time required to find and evaluate potential resources, the collaboration efforts involved in working with other community agencies, and the limited funding available for housing services appropriate for people in early recovery. In addition to addressing these considerations, you will need to ensure that individuals who are homeless can continue to participate in services and continuing care. You will need to work with them to manage transportation, mental health, healthcare, financial, criminal

justice, and employment issues that are complicated by homelessness. The reality is that an individual who is homeless is in crisis and has housing needs that must be addressed in a very limited period of time.

Some frontline resources often used to help individuals who are homeless make the transition to more stable recovery are residential recovery and other housing options that have a primary focus on recovery from substance abuse and mental illness. Generally, these resources fall into four categories: halfway houses, ¾-way houses, sober living residences for clients with substance use disorders, and supportive housing for clients transitioning out of intensive mental health treatment or treatment for co-occurring disorders. With perhaps a few exceptions for clients from the criminal justice system, all clients in these residences enter and remain voluntarily.

Halfway houses with a primary focus on substance abuse or mental illness recovery generally offer more intensive treatment than other recovery housing options, have the most structured programs, and are the most likely to be professionally staffed. They also generally are the most time-limited service (usually 30–60 days). Persons are likely to enter a halfway house on completion of intensive treatment. In a halfway house, residents are expected to participate in regularly scheduled (usually daily) individual and group treatment, and regular attendance at 12-Step or other self-help and recovery programs is either mandated or actively encouraged. Program rules often limit the amount of time residents can spend away from the house and the contacts they can have in the community. Programs also specify meal and sleeping times, provide medication management, and usually have an active focus on relapse prevention and recovery maintenance. Case management services, provided by counselors or specialized case management staff, are often available. Frequently, supportive services, such as employment assistance, health care, and financial assistance, are available to residents either "in house" or through referral.

Generally, **¾-way houses** have fewer staff persons with professional credentials and may only be staffed by a house manager and assistants. Residents have more autonomy in managing their time and community contacts, and (unless employment is not a consideration for the client) they are usually employed, expected to be seeking employment, or in a job training and support program. Significantly less treatment by professionals is offered in ¾-way houses than in halfway house programs. Residents are expected to maintain abstinence, monitor psychological symptoms, and manage their medication with the support of staff; are often expected to participate in continuing care and 12-Step recovery programs; and may be encouraged (after some time in the house) to seek other residential options. Clients may have the option of staying in a ¾-way house for a longer period than in a halfway house.

In recent years, a variety of **sober living housing** options have emerged for people in recovery from substance use disorders and fill a critical need for housing for people in recovery who do not need more intensive residential services. The best known sober living facilities today are Oxford Houses (http://www.oxfordhouse.org). The Oxford House movement has residential facilities throughout the United States that are drug free, self-supporting, and democratically governed by the residents and a board of directors. They normally have 8 to 15 residents. Complete abstinence from alcohol and illegal or illicit drugs is a requisite for residence. Residents can live in the house as long as they desire. There is no professional staff and there are no requirements about attending treatment. Participation in 12-Step programs is

strongly encouraged. Other sober living houses that are not affiliated with Oxford Houses may also be available in your community.

Community transitional **supportive housing** can be an intermediate step between leaving an inpatient facility for substance abuse and/or mental health treatment and living independently in the community. Supportive housing programs for people leaving intensive treatment ordinarily provide an affordable place to live; close links to treatment; support in medication maintenance; services to develop and enhance skills in household, job, and financial management; and day-to-day support from professional and paraprofessional staff. Supportive housing reduces isolation, reduces relapse rates, offers early intervention so that living problems do not escalate, and provides safe housing for people at a very vulnerable point in their lives.

Housing services focused primarily on safe housing and social services

Substance use-related designations for shelter and housing

Housing and shelter programs are sometimes defined by policies related to substance use on and off the premises. Different types of housing are appropriate for clients in different stages of change for substance use behavior and who are, in turn, ready for varying levels of service intensity. In housing, "wet," "damp," and "dry" refer to these levels of service intensity and a concomitant demand for abstinence. Exhibit 1-7 describes each program type. Although programs are defined by allowed substance use, their services are not restricted to people with substance use disorders.

Sometimes, people are placed in housing when they are in the precontemplation stage of change regarding their substance use or mental health issues. They may show little or no motivation or behavior suggesting that they would even consider addressing their problems. Even so, you may still have several options for working with clients who are in the precontemplation stage, including:

- Providing information about recovery and resources that are available, if and when they do sense a need to do something about their use.
- Building stronger relationships focused on their ability to contact a service provider if they decide to get help for substance use.
- Supporting their efforts to consider or act on changing substance use behavior—for instance, by supporting efforts toward abstinence, even for brief periods.
- Helping individuals develop or improve coping skills for managing life without substances.
- Locating housing in congregate living settings with staff members on site who can provide safety and support.

Concerns, such as drug trafficking on the premises, may be a particular risk factor for some persons attempting to maintain abstinence. Onsite staff persons have a greater opportunity to build relationships by sharing activities and conversation. They can also assess an individual's functioning and engage them in appropriate services.

Services for veterans who are homeless

In addition to services available in the community and local treatment system, veterans who are homeless may be eligible for VA services. Eligibility varies for each of these services. In general, eligibility is least restrictive for entry to VA homelessness programs. Those who have a service-connected disability or VA pension are most likely to access VA services. Nearly every VA hospital has a Health Care for Homeless Veterans (HCHV) Program caseworker who can inform you about local services and eligibility criteria. VA services for

Exhibit 1-7: Housing Designations and Readiness to Change Substance Use

Housing Type	Relevant Stage of Change	Description of Housing and Supportive Services
Wet Housing	Suited to precontemplation or contemplation stages of change	• Permits use of legal substances (i.e., alcohol) on premises. • Meets basic needs for safe shelter; increases client readiness to accept other services. • Staff creates consistent, empathic relationships with clients and addresses behaviors related to substance use (e.g., loud, destructive parties) to help clients recognize how substance use affects their lives, goals, and chances of staying housed. • Residents are engaged in treatment and other services as they are ready.
Damp Housing	Suited to contemplation and preparation stages of change	• Abstinence is recommended but not required; intervention occurs if safety becomes an issue. • Meets basic needs for safe shelter; increases client readiness to accept other services. • Staff createes consistent, empathic relationships with clients and addresses behaviors related to substance use (e.g., loud, destructive parties) to help clients recognize how substance use affects their lives, goals, and chances of staying housed. • Residents are engaged in treatment and other services as they are ready.
Dry or Sober Housing	Suited to action or maintenance stages of change	• Strict abstinence policy—substance use results in termination of housing. • Staffed group homes (i.e., transitional or permanent supportive housing programs) or independent group sober living, like Oxford Houses. Residents pay rent, utilities, and other household expenses.

Source: Hannigan & Wagner, 2003.

veterans who are homeless vary geographically and include the following:

- HCHV: VA outreach workers and case managers help establish eligibility for VA medical services, develop appropriate treatment plans, and screen for community placement.
- Stand Downs: These give veterans who are homeless 1–3 days of safety and security where they can obtain food, shelter, clothing, and other types of assistance, including VA-provided health care, benefits certification, and linkages with other programs.
- Drop-In Centers: These programs are a daytime sanctuary where veterans who are homeless can clean up, wash their clothes, and participate in therapeutic and rehabilitative activities.

Recovery-oriented and rehabilitative treatment programs for veterans who are homeless include:

- Domiciliary Care for Homeless Veterans (DCHV): DCHV provides residential treatment and rehabilitation to veterans who are homeless.
- VA Grant & Per Diem Program: This program subsidizes residential treatment and transitional housing.
- VA-based substance abuse treatment programs: These can be found using the

SAMHSA Treatment Locator (http://findtreatment.samhsa.gov/).

- Supportive Housing: This program provides ongoing case management services to veterans who are homeless. The emphasis is on helping veterans find permanent housing and providing clinical support to keep veterans in permanent housing.
- Veterans Affairs Supportive Housing Program with HUD: This program provides Section 8 voucher program and permanent housing and treatment for veterans who are homeless and have mental and substance use disorders through VA outreach, clinical care, and ongoing case management services.

Homelessness services in rural areas

People who are homeless in rural and remote areas typically live temporarily in campers, cars, abandoned buildings, tent encampments, or with a succession of friends or family in overcrowded, substandard housing (Dempster & Gillig, 2006). As a result, people who are homeless in rural areas are often less visible than those in more urban settings and may not be counted in census or other surveys. Outreach and engagement are different in rural areas than in urban centers, because people who are homeless in rural areas are more difficult to identify. In addition, outreach and engagement activities are successful only if you can refer individuals to services relevant to rehabilitation from homelessness.

Job opportunities, transportation, health and social services, and shelter options tend to be more limited in rural areas. Individuals with mental illness who are homeless and unable to live with family in rural areas may be particularly vulnerable and may migrate to larger population areas to obtain housing and services. In rural areas where the predominant employment is agriculture, migrant workers who are homeless and depend on employer-supplied housing can be particularly vulnerable. Often, the housing offered for temporarily employed migrant workers is substandard and inadequate, creating a unique situation of homelessness or near homelessness.

To create temporary shelter, some providers develop contracts with local property owners in which an agency pays a monthly rate for sleeping rooms used as temporary housing until other arrangements are made. This may be more cost-effective when actual numbers of clients do not warrant larger shelter programs; it gives the individual and the agency flexibility to better prepare for more adequate housing. In some locations, faith-based communities can temporarily house people for brief periods in members' homes, church buildings, or in low-cost motels paid for with money set aside to help those in need.

SAMHSA's PATH program provides formula grants to States, which they can then use for homelessness services in rural areas. The grants can be used for outreach, screening, behavioral health services, case management, and other supports for housing assistance. A primary problem is that, given the actual number of individuals and families needing a specific form of housing among a dispersed, rural population, costs for the construction of congregate housing or shelters can be prohibitive. As a result, developing an adequate supply of rental stock and providing rental subsidies may take on particular importance. There is often a waiting list in rural areas for housing that is available through programs serving people who are homeless.

Where adequate services do not exist, workers in PATH-supported outreach and engagement programs in rural areas often carry sleeping bags, camping gear, and food. Some programs employ former consumers who can establish good rapport with individuals who are homeless. The programs work to create

linkages and good relationships with nearby communities and agencies (Robertson & Myers, 2005). The National Alliance to End Homelessness (2010) emphasizes using naturally occurring support networks in rural areas to provide support to people who are homeless. Involvement of local area leaders and stakeholders promotes an inclusive, collaborative system.

You Can Do It

Working with clients who are homeless or at risk of homelessness certainly increases the complexity of your job. Clients who are facing homelessness have unique personal and environmental dilemmas that require special care and attention. Nevertheless, with some additional knowledge, enhanced skills, and an examination of your own attitudes toward homelessness, ***you can do this work*** effectively. The skills required will simply complement the skills you already have as a treatment or prevention professional. The additional knowledge you need will benefit not only your work with people who are homeless, but also your work with any person who has layered problems. A significant milestone in professional growth is expanding your horizons and capabilities to work with different types of people, some of whom have more complex needs than others.

In the next chapter, you will meet several people who are homeless and in various stages of need, and you will examine how your new and expanded knowledge, skills, and attitudes can be applied in realistic treatment and prevention service situations.

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