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How People Experience the Hospital to Home Project

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by

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

Many individuals who experience chronic homelessness with complex medical and mental health issues use the Emergency Room often. A new program called the Hospital to Home Program (HHP) has been created for people who have at least one chronic health condition, have been to the emergency room five or more times in the previous year, and have a history of chronic homelessness. This qualitative research project sought to explore the participant's experiences of the HHP as there has been no qualitative research done with the program currently. Seven participants were asked open-ended questions to elicit responses about their quality of life being in the program, about their housing, and what Guild Incorporated has helped with. The findings indicate that the participants were all housed, they felt their overall quality of life was better, and they reported some of the barriers they previously faced and are currently facing. It was found that participants of the HHP enjoy being in the program and feel they have benefited greatly from the services.

Keywords: Homeless, Hospital to Home, Emergency Department, Chronic Health Conditions

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Table of Contents

How People Experience the Hospital to Home Project

A common problem is that many people who experience chronic homelessness with complex medical and mental health issues use the Emergency Room for often nonemergency issues and do not have many supports to help them through their lives. Regions Hospital identifies people who have at least one chronic health condition, have been to the emergency room five or more times in the previous year, and have a history of chronic homelessness. Guild Incorporated is an organization dedicated to helping people with Serious Mental Illness who often struggle with homelessness and chemical dependency. Regions and other health organizations refer the clients to Guild Incorporated and the clients are put on a team of mental health practitioners and nurses. The team helps the client find stable housing, helps them receive financial support, helps with medication, and helps the client with any chronic health condition. This program is called the Hospital to Home.

The Hospital to Home Program is important for people with mental illness. There are many people who struggle with medical issues, mental health conditions, and are often homeless and they use the emergency room three times the normal rate (Kushel, Perry, Bangsberg, Clark, & Moss, 2002). People who are mentally ill are more susceptible to medical conditions, Atkinson et al (1997) found that people with severe mental illness lead less quality lives and reported little satisfaction with their health and functioning than those without mental illness. Jones et al (2004) found that of 147 with serious mental illness 74% of them had been given a diagnosis of one chronic health problem. It was discovered that 50% of the people with serious mental illness had been

diagnosed with two chronic health condition. This implies that those with mental illness are likely to have a chronic health condition and caring for their illnesses can become expensive and can lead people to homelessness. There are much higher rates of serious mental illness among the homeless community than among those who have stable housing (Draine et al, 2002). The Hospital to Home project provides social workers/mental health practitioners, and nurses on a team through Guild Incorporated to help people with their complex mental and physical illnesses.

The Hospital to Home Program is not only important for people who are homeless with illnesses but it is also important for the community financially. People who are homeless often do not have access to private insurance so emergency room visits are costly. Those who are homeless use the emergency room often cannot pay for visits therefore the services become public costs. Providing social workers and nurses to help the clients can serve as a preventative measure to using the emergency room and can save the community money.

The Hospital to Home program is currently showing success. The immediate impacts of the program shows all of the clients suspected of mental illness have been appropriately screened and are receiving treatment (Dillon, 2011). All of the clients are being served in the community rather than housed in a residential facility (Dillon, 2011). The clients regularly see a physician to provide medical treatment for chronic health conditions (Dillon, 2011). The clients have all been housed in private rental facilities (Dillon, 2011). The results are promising and after this report was released Guild Incorporated received more referrals and have since increased clients (Dillon, 2011).

The reports that have been done are mostly qualitative and the numbers show that this program has been effective in helping people. A missing piece of this research is the quantitative work because it can provide new ideas and put meaning behind the research. Qualitative research could give new ideas about what people are struggling with and the barriers they face. Social workers can benefit from this research because it may provide more of an understanding of what these clients are experiencing. This study evaluates Hospital to Home's participant's perceptions of the quality of their lives after enrollment and the barriers and/ or issues that may occur as people access services in the program by interview.

Literature Review

This study examines experiences of individuals who have at least one chronic health condition, have been to the emergency room five or more times in the previous year, and have a history of chronic homelessness. To attempt to understand participants of Hospital to Home a review of the literature is necessary in the area of homelessness. Mental illness, race, gender, age, and chronic illness can be a part of the cause or effect of homelessness and each play a role in how one experiences homelessness. These complex issues can compound and individuals who are homeless may find they need to use the emergency room frequently. Guild Incorporated and Regions have developed a program that provides wrap around services for clients to address these complex issues.

Homelessness in the U.S.

The homeless population is an ongoing issue in the U.S. The National Health Care for the Homeless Council (2013) defines homelessness as an:

> individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing. A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation (2013 National Health Care for the Homeless Council).

Homelessness occurs in the U.S., and an estimated 3.5 million individuals are likely to experience homelessness in a given year and around 649,000 people in the U.S. are homeless on a given night (Khadduri, Culhane, Leopold, Rothschild, Cortes, 2010).

Mental Illness and Homelessness

Individuals who are homeless can have other illnesses and complications that can interfere with housing, like mental illness. According to the Substance Abuse and Mental Health Service Administration (2009), 26% of the U.S. homeless population have a severe mental illness, compared to 5% of those who are not homeless that suffers from severe mental illness (National Institute of Mental Health, 2009). The U.S. Department of Housing and Urban Development (2009) found that 26.2% people who were in shelters also had a serious mental illness. A study conducted by Page, Petrovich, and Kang (2012) surveyed 255 social workers, clinical supervisors, psychologists, counselors, and nurses who all work in programs designed to help people with mental illness who are also homeless. Page et al. (2012) compared individuals who are homeless to mentally ill homeless individuals and found three major characteristics within the mentally ill

homeless population: those who have mental illness and experience homelessness had less social support, were more likely to be homeless more than six months, had high amounts of victimization, and have less insight into their mental illness. This information implies that being homeless and having a mental illness creates significantly more barriers than being homeless without a mental illness.

Serious mental illness is defined as a mental illness that substantially interferes with one's ability to function and is estimated to affect 8.3% of the U.S. adult population (National Institute of Mental Illness, 2002). These illnesses including mood disorders including bipolar disorders, major depression, anxiety disorders including panic disorders, generalized anxiety disorder, phobias, and posttraumatic stress disorder, and nonaffective psychoses including schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, and psychotic disorder not otherwise specified (Jans, Stoddard, & Kraus, 2004). The following section provides information on specific mental illnesses to inform the reader of mental illnesses homeless individuals may face.

Bipolar 1 disorder occurs in .6% of the U.S. population (American Psychiatric Association, 2013). Bipolar disorder includes bipolar I and bipolar II disorder and both illnesses include at least one episode of mania or hypomania and one episode of depression (American Psychiatric Association, 2013). A manic episode from a Bipolar I person is described as an unusual period of time characterized by constant, extensive, or irritable mood and an increased goal directed activity or energy which lasts at least one week (American Psychiatric Association, 2013). Mania has characteristics like a sense of grandiosity, less of a need for sleep, more talkative, racing thoughts, being easily

distracted, and being involved in high risk behaviors (American Psychiatric Association, 2013). A manic episode has severe impairment in social or occupational functioning and there may be a need for hospitalization (American Psychiatric Association, 2013). Hypomania is often seen as a less intense mania characterized by grandiosity, less need for sleep, more talkative, easily distracted, and often the person engages in high risk behaviors (American Psychiatric Association, 2013).

Major depression occurs in 7% of the U.S. population (American Psychiatric Association, 2013). Major depression is characterized by depressed mood nearly every day with feelings of emptiness and hopelessness with decreased interest in things that formerly brought pleasure (American Psychiatric Association, 2013). Often there is significant weight loss, insomnia or hypersomnia, psychomotor agitation, loss of energy, feelings of worthlessness, less of an ability to concentrate or make decision, and thoughts of death or suicidal ideation (American Psychiatric Association, 2013). These symptoms cause significant impairment in social and/or occupational functioning and causes significant distress (American Psychiatric Association, 2013). (DSM).

Anxiety disorders are illnesses that have characteristics of intense fear and unease (American Psychiatric Association, 2013). Phobias occur in 7%-9% of the U.S. population and are an anxiety disorder in which a person has intense fear over an object or a situation (American Psychiatric Association, 2013). The object or situation causes significant distress and/or impairment and the fear is often greater than the actual danger involved (American Psychiatric Association, 2013). Panic disorders are an intense and abrupt flood of fear which is characterized by accelerated heart rate, sweating, shaking, shortness of breath, nausea, dizzy, chills, fear of dying or losing control, and chest pain

and occurs in 2%-3% in the population (American Psychiatric Association, 2013). People with Generalized Anxiety Disorder struggle with excessive anxiety and worry characterized by restlessness, fatigue, irritability tense muscles, and sleep disturbances and it occurs in 2.9% of the U.S. adult population (American Psychiatric Association, 2013).

Posttraumatic stress disorder in adults occurs after experiencing or witnessing a trauma, or learning about violence or accidental trauma in family and friends (American Psychiatric Association, 2013). The symptoms involved in Posttraumatic stress disorder intrusive thoughts and/or dreams about the traumatic events, flashbacks that feel like the event is occurring again, intense or prolonged distress at exposure to internal or external stimuli that may resemble the traumatic event (American Psychiatric Association, 2013). Often the individual will avoid stimuli that are associated with the traumatic event such as memories, thoughts, people, places, and situations (American Psychiatric Association, 2013). People may have an inability to remember important aspects of the event, may blame themselves for the trauma, may have diminished interest in things formerly found interesting, feelings of detachment, depressive symptoms, sleep issues, and hypervigilance (American Psychiatric Association, 2013). The lifetime risk of for posttraumatic stress disorder is 8.7%.

Schizophrenia disorders are defined by characteristics like delusions, hallucinations, disorganized thinking and speech, disorganized and abnormal motor behavior, and negative symptoms like reduced emotional appearance (American Psychiatric Association, 2013). Schizophrenia occurs in .3%-.7% (American Psychiatric Association, 2013). Schizoaffective disorder has many of the symptoms of

schizophrenia with symptoms of a major mood disorder. Schizoaffective disorder occurs in an estimated .3% percent of people (American Psychiatric Association, 2013). Delusional disorder is the presence of one or more delusion such as intense jealousy type or somatic type and it will effect .2% of people (American Psychiatric Association, 2013). Brief psychotic disorder lasts between on day and one month and includes delusions, hallucinations, disorganized speech, and/or catatonic behavior or severely disorganized (American Psychiatric Association, 2013). People who experience homelessness may experience mental illnesses such as the ones mentioned above. It is important to understand how mental illness affects individuals who are homeless because Hospital to Home has documented many of their participants have a mental illness which can severely impact their lives.

Homelessness and Gender

People who experience homelessness may issues related to gender, race, sexual orientation, age, substance abuse, and physical health which may be a part of the cause of homelessness and/or can make being homeless significantly more difficult. Gender plays an important role in the homeless community. Seventy five percent of the adult homeless community are men (City Shelter Commission, 2009). Homeless men are more likely to struggle with drug and alcohol addiction, unemployment, crime, and are more likely to commit suicide (Barak, Cohen, & Aizenberg, 2004). Homeless men are much less likely to ask for help for physical or mental illness (Groeschel, Wester, & Sedivy, 2010). Homeless women are more likely to be accompanied by family members, generally children, then are homeless men making their expenses like clothing and food much higher (Burt & Cohen, 1989). Homeless women have high rates of sexual exploitation,

harassment, and sexual violence (Wenzel, Leake and Gelberg, 2000). Homeless women report using certain strategies to prevent victimization like attempting to pass as a more masculine female or even trying to pass as a male (Huey & Berndt, 2008).

Homelessness and Race

Race and culture can play a part in homelessness. Recent data from the U.S. conference of Mayor (2008) found that an estimated 42% of the homeless population is African American, 38% identify as Caucasian, 20% are Hispanic, 4% are Native American, and 2% are Asian. Homeless Latino respondents tend to be younger, less likely to report victimization while living on the streets, and nearly half of them reported being first generation immigrants (Gamst, Herdina, Mondragon, Munguia, Pleitez, Stephens, and Vo, 2006). Homeless White and African American respondents had lower functioning in daily living skills, anxiety, depression, and relation to self and others (Gamst et al., 2006).

Homelessness and Sexual Orientation

Sexual orientation may play a role in homelessness. A study by Rosario, Schrimshaw, and Hunter (2012) interviewed 156 youth recruited by the Lesbian Gay Bisexual community. They found that 48% reported a history of homelessness, 38% had experienced being thrown out by their parents, 57% ran away from their homes at some point, 20% of the youth experienced running away and being evicted by their parents (Rosario et al., 2012). Tyler (2008) and Whitbeck, Chen, Hoyt, Tyler, and Johnson (2004) found that GLB young adults experience more sexual victimization than heterosexual young adults. Whitbeck et al. (2004) found that adolescent homeless gay,

lesbian, or bisexual people were more likely to have been abused by caretakers and sexually victimized on the streets and more likely to have a mental illness.

Homeless Youth

Every year hundreds of thousands of adolescents spend the night homeless (Hammer, Finkelhor, & Sedlak, 2002). There are four general categories identified by Farrow, Deisher, Brown, and Kulig (1992) of reasons youth become homeless. The first category is situational runaways and these youth tend to leave their homes over a disagreement and end up spending a limited number of nights homeless and eventually will return home (Farrow et al.,1992). The second category is the chronic runaways who will stay homeless for long periods of time due to serious issues like abuse (Farrow et al., 1992). The third category of youth who are homeless are the throwaways who are forced to leave their homes by their caregivers (Farrow et al., 1992). The throwaway category of youth represent almost 50% of the population and are often more susceptible to drug use and suicide attempts (Ringwalt, Greene, & Robertson, 1998). The last category of youth who are homeless are those that grow up in foster care or in institutional facilities. Merscham, Leeuwen, and McGuire (2009) found higher rates of mental illness, substance abuse, trauma, and suicidal ideation than in normal teenagers.

Homeless with Substance Abuse Issues

Substance abuse is a problem in the homeless community, Hartwell (2003) estimates that around 20% to 80% of the homeless population is actively using substances. In a study with 210 homeless people Teesson, Hodder, and Buhrich (2003) found that individuals who are homeless were six times more likely to have drug use and

thirty three times more likely to have opiate use issues. Substance abuse can occur because of homelessness and can be the cause of homelessness (Zerger, 2002). Johnson, Freels, Parsons, and VanGreest (1997) investigated 303 homeless people. They found that drug use was a predictor in first becoming homeless (Johnson, et al, 1997). Johnson and Chamberlain (2003) found that 43% of their sample had issues with substance abuse. Of that sample, one-third of them reported substance abuse before they became homeless and two-thirds of the sample reported substance abuse issues after they became homeless (Johnson & Chamberlain, 2003). Johnson and Chamberlain (2003) also looked into age as a factor in homelessness and found that younger people were more likely to develop a substance abuse issue after becoming homeless than older adults. Finally, Johnson and Chamberlain (2003) looked into substance abuse as it related to the length of time being homeless and found that people who are homeless and using substances are likely to remain homeless for twelve months or longer.

Homeless with Developmental and Physical Disabilities

There are many obstacles people who are homeless have to overcome that have played a role in becoming homeless, have occurred because of homelessness, and/or have made being homeless more difficult. Padgett, Smith, Hennwood, and Tiderington (2012) interviewed formerly homeless individuals with serious mental illness about adverse life events that may play a role in homelessness. They found that poor health, poverty, and social isolation were frequently reported (Padgett et al, 2012). Common disabling conditions identified by United States Department of Housing and Urban Development (found on the registration form) are substance abuse disorder, serious mental illness,

developmental disabilities, and chronic physical illnesses. These conditions may impair an individual's ability to perform occupationally and in areas of daily living.

Developmental disabilities have been found to play a part in the homeless population. Morton and Cunningham-Williams (2009) found that in a sample of 62 individuals experiencing homelessness 79% had a learning disability, 12.9% were mentally disabled, 1.6% fell on the autistic spectrum, 3.2% were ADHD, and 11.3% had a behavioral disorder. Research shows that people who have an intellectual disability have a difficult time finding a job and if they do have a job, they do not get paid well which may force them to live in poverty (Mirfin-Veitch, 2003). In a study researching intellectual disabilities among the homeless population, Mercier and Picard (2011) found that the majority of people had been homeless for more than 4 years. They also found that many of them presented with co-occurring disorders mental health conditions and substance abuse (Mercier and Picard, 2011).

People who are homeless often have high rates of physical illnesses (Breakey, Fischer, Kramer, Nestadt, Romanoski, Ross, Royall, Stine, 1989). Medical conditions found in the homeless population vary, Guild Incorporated has identified some in their referral forms that are common from their homeless population such as Coronary Artery disease, Congestive Heart Failure, Asthma, COPD, Hypertension, TBI, Seizure Disorder, Diabetes, Renal Failure, HIV/AIDS, and cancer. O'Connell (2005) found that premature death for homeless individuals was generally related to a chronic medical condition. After exploring how people who experience homelessness and the correlation between different variables like race and substance abuse it was found that individuals who

experience homelessness may not have opportunities to access services and these services are often used are crisis services.

An estimated 1.7 million people suffer a traumatic brain injury each year in the US (Faul, Xu, Wald, & Coronado, 2010). Traumatic Brain Injury is a jolt to the head or a penetrating head injury that disturbs the normal functioning of the brain (Black, 2011). The severity ranges from mild, a short change in the brains consciousness in which people may not be aware of, to severe, unconsciousness or amnesia after the injury which can be seen with magnetic resonance imaging (Black, 2011). The life time prevalence among homeless participants was 53% for any traumatic brain injury and 12% for moderate or severe traumatic injury (Hwang, Colantonio, Chiu, Tolomiczenko, Kiss, Cowan, Redelmeier, & Levinson, 2008). 70% of the respondents had their first traumatic brain injury before they became homeless (Hwang, et al., 2008). A history of moderate or severe brain injury was associated with significantly increased mental illness, higher likelihood of seizures, drug problems, poor physical health, and poorer mental health status (Hwang, et al., 2008). Corrigan and Deutschle (2008) found that around 70% of people who struggle with co-occurring mental illness and substance use had a history of traumatic brain injury. From this research it is apparent physical injuries, mental illness, and substance abuse are all correlated.

Homeless Using the Emergency Room

Studies show that people who are homeless are 3 times more likely to use the emergency room than those that are housed (Kushel, Vittinghoff, & Haas, 2001). Homeless people also use the emergency room more frequently (Mandelberg, Kuhn, Kohn, 2000). In a study by Kushel, Perry, Bangeberg, Clark, and Moss (2002) in which

they interviewed 2,578 homeless people and marginally housed people who used the emergency room. The researchers found that of those 2,578 people, 40.4% had used the emergency room in the last year, 7.9% of the respondents were chronic users of the Emergency room (3 or more visits) (Kushel et al, 2002). Those that used the emergency room chronically had less stable housing, victimization, arrests, physical and mental illness, and substance abuse (Kushel et al, 2002). Sadowski, Kee, VanderWeele, and Buchanan (2009) conducted a study on whether case management and a housing program has a better or worse effect on people who are homeless with chronic medical illnesses than the usual care after hospitalization. The intervention group of 201 people was providing a social worker and a housing program while the control group or usual care, of 204 people received a hospital social worker with a discharge plan; often these individuals were transported to an overnight shelter (Sadowski, et al 2009). Participants had to have at least one of the following medical conditions: hypertension or diabetes requiring medication, thromboembolic disease, renal failure, cirrhosis, congestive heart failure, myocardial infarction, atrial or ventricular arrhythmias, seizures within the past year or requiring medication for control, asthma or emphysema requiring at least 1 emergency department visit or hospitalization in the past 3 years, cancer, gastrointestinal tract bleeding, chronic pancreatitis, and HIV (Sadowski, et al 2009). After the 18 month interview Sadowski et al (2009) found that the intervention group was doing statistically better than the control group: there was a 29% reduction in hospital days and a 24% reduction in emergency department visits.

Salit, Kuhn, Hartz, Vu, and Mosso (1998) studied the discharge records of 18,864 homeless people and 383,986 low-income adults who entered New York City's hospitals

to discover why they had entered, how long they stayed, and what their symptoms were. Salit et al. (1998) found that 51.5% of the homeless people were admitted for treatment of substance abuse or for mental illness compared with 22.8% of the lower income patients. They found that 19.7% of the homeless admissions were from trauma, respiratory disorders, skin disorders, and infectious diseases (Salit et al., 1998). Approximately eighty percent of the patients experiencing homelessness either had a principal or secondary diagnosis of mental illness or substance abuse (Salit et al., 1998). The homeless patients stayed in the hospital 4.1 days longer than the other patients (Salit et al, 1998). The cost of the additional days spent in the hospital for the homeless people averaged $4,094 for psychiatric patients, $3,370 for patients with AIDS, and $2,414 for all types of patients (Salit et al, 1998). The use of services for those struggling with complex issues and understanding why people access them is important in creating programs and services that address these specific needs. People who experience homelessness often have limited access to these services most notably affordable housing.

Housing the Homeless

Finding housing for people who are homeless is important because it can provide basic stability for people to be able to treat co-occurring illnesses. Sun (2012) recommends that the four components in helping the chronically homeless with co-occurring disorders are helping clients to transition easily from institutions to the community, helping them apply for government entitlements, linking clients with supported housing, and helping them enter a program to assist them with their mental illness and/or substance abuse. Pearson, Montgomery, and Locke (2009) performed a

study exploring the use of housing first, which is an idea that before people can get help with their mental illness or their substance use issues they need to be off the streets and housed because research shows that people will stay enrolled in programs longer when they are adequately housed. There were 80 participants who had a serious mental illness who were considered homeless involved in the study (Pearson, Montgomery, &Locke, 2009). Three organizations were involved in getting people housed and Pearson found that one year after being housed, 84% of the participants remained housed (Pearson, Montgomery, & Locke, 2009).

Residential Stability

People with complex health issues who are homeless often experience a cyclical pattern of being housed to being homeless (Hopper, Jost, Hay, Welber, & Haugland, 1997). Engagement in housing services can be difficult for individuals who are homeless due to previous denial of services, not knowing where to go for help, staff issues, confusion, frustration in applying for services (Rosenheck and Lam, 1997) and their previous negative experience with similar services (Sosin and Grossman, 2003). Some programs may require that clients be sober which can be a loss of personal control over one's life. (Padgett, 2007). Housing first programs are based on the idea that housing is a right and offering this immediately before discussion of treatment or psychiatric services is more helpful/effective (Ridgeway and Zipple, 1990). After an interview with clients who had been homeless Jost, Levitt, and Porcu (2010) found five major themes, people had negative perceptions of homeless services, people had to be ready to leave the streets, people had to believe the program would help them get housing, adapting to their surroundings and discovering benefits of being housed was difficult but important, and

lastly knowing supports were in place for their success was important once a person who is chronically homeless is housed, the need to retain housing is important. This housing retention could be contingent on treatments such as substance abuse treatments or on housing stability characteristics such as the ability to clean, comfortableness of having one's own place, and ability to perform daily living skills. Those with clinically complex health issues may experience issues with finding affordable housing and if they find housing they may struggle with maintaining residential stability. Guild Incorporated is an organization that understands complex clinical health issues and seeks to help people in a collaborative effort to build a healthy happy life for clients.

Guild Incorporated

The Hospital to Home project was developed for people who chronically homeless and have a chronic medical condition. Regions Hospital in St. Paul identifies people who meet the criteria for admission into the program and sends that information to Guild Incorporated. Guild Incorporated is a nonprofit organization with multiple locations in St. Paul Minnesota (Guild Incorporated, 2013). Guild Incorporated is a realistic place for the Hospital to Home program to be held because they already serve clients who have a serious and persistent mental illness and/or serious mental illness. The mission of the organization is to help people with mental illness lead quality lives by providing integrated treatment and services (Guild Incorporated, 2013). The multiple service areas include Community Treatment Services, Residential Services, Delancey Services, Employment Service, and Rehabilitation Services (Guild Incorporated, 2013). The Community Treatment Services consists of Integrated Case Management and Care Coordinated Services who help the clients gain access to medical,

social, educational, vocational, financial, and other important services which can aid in mental and physical health (Guild Incorporated, 2013). Another service in the Community Treatment is the Assertive Community Treatment who helps people who have severe and hard to manage symptoms of mental illness (Guild Incorporated, 2013). This service is delivered to where the client is and they work in multidisciplinary teams to provide more comprehensive service (Guild Incorporated, 2013).

There are multiple residential services within three different houses. The Crisis Stabilization Residential Services help individuals who are in psychiatric crises stabilize so they avoid homelessness, hospitalization, or incarceration (Guild Incorporated, 2013). The Intensive Residential Treatment Services assist in enhancing psychiatric stability, personal adjustment, and skills needed to live independently (Guild Incorporated, 2013). Lastly, the Long Term Supportive Housing provides 24/7 services for residents who need a higher level of care (Guild Incorporated, 2013). Delancey Street program serves people who are chronically homeless, who have a serious mental illness, and those who struggle with substance use (Guild Incorporated, 2013). Delancey Street also manages a pilot program for section 8 housing units (Guild Incorporated, 2013). The Delancey apartments have 13 units, all the residents have mental illness, and there is always mental health worker at the front desk so any of the residents can always receive help when needed (Guild Incorporated, 2013).

Guild Incorporated also has employment services for the clients. The employment services works with all the teams to help client's acquire and maintain employment (Guild Incorporated, 2013). Guild Incorporated has already been working

with the homeless, medically ill, and mentally ill population so they understand the issues and complications surrounding them.

The Hospital to Home Project

The Hospital to Home Project was developed for people who use the emergency room five or more times in the last year, people who have a chronic health condition, and for people who have chronic homelessness. The Hospital to Home program has already produced some baseline and follow quantitative results of the study. For example, the Wilder Research (2011) found that upon intake seven participants who were diagnosed with a serious mental illness, all participants had used the emergency room at least five time that year, all participants had at least one chronic medical condition, and almost all of the participants were diagnosed with a substance use problem. Wilder also found that many of the clients had criminal histories.

In addition, Wilder Research (2012) has done some follow up work after the participants entered the program. They found that there was a steady decrease in emergency room (ER) visits, from six months prior to the study the group had 110 visits, six months after enrolment the ER visits went to 77 times, six months after that the ER visits went to 41, and finally six months after that the ER visits were at 21 (Wilder Research, 2012). Not only did the total amount of visits to the ER decrease but each participant decreased their use of the ER (Wilder Research, 2012). The participants increased their use of clinics and services went up as their health issues were now being addressed (Wilder Research, 2012). Participants were accessing their medications more consistently after enrollment (Wilder Research, 2012). The number of medications being filled went down. All of the participants were in stable housing 3 months after

enrollment into the program (Wilder Research, 2012). The participants mostly had a higher rating than before enrollment in the self-sufficiency matrix which indicates to what degree are people in need of support with their mental health, community involvement, life skills, mobility, safety, substance abuse, employment, education, food, healthcare, family relations, legal issues, and income (Wilder Research, 2012). A higher score indicates the participant is more self-reliant in these areas (Wilder Research, 2012). This report shows that the Hospital to Home project is starting to achieve their goals of better care, improved outcomes for people, and reduced costs of care.

Conclusion

Homelessness is a major problem in the U.S. and often they have higher rates of mental illness and chronic physical illness. This population suffers greatly and uses hospital's emergency rooms or departments at high frequencies. This pattern shows us that people with complex mental and physical health issues may not be getting the services needed to manage their health and find adequate housing. Consequently, these emergency room visits are not being paid for and the state funds have to pay. The Hospital to Home program is designed to target this hard to reach and clinically complex population. The preliminary results with seven participants were positive and showed that with the help of a multi-disciplinary team, persons who are homeless can be housed and become more self-reliant in caring for their health issues. These results have subsequently increased the referrals from the hospital and the participant number has gone from 7 to 25. Although, this quantitative data is promising some of the research that is missing is talking with the participants to find out how this program is effecting their lives. This study evaluates Hospital to Home's participant's perceptions of the quality of

their lives after enrollment and the barriers and/ or issues that may occur as people access services in the program by interview.

Conceptual Framework

All social workers view their clients and the problems surrounding them through a lens that informs us. Interpretations of themes will be developed from different theories grounded in social work. The use of these theories will inform us of the unique experiences people with mental illness, homelessness, and physical illnesses have after entering a program that addresses these complex needs. The three theories that are used to view the participants and their experiences are Systems Theory, Empowerment, and Maslow's Hierarchy of Needs.

Systems Theory

Karl Ludwig von Bertalanffy was a researcher who contributed to theoretical biology, theoretical psychology, cancer research, the philosophy of science, and scientific methodology (Forte, 2007). He imagined a way to use all of these principals because he was against the splitting of scientific theories into multiple disciplines (Forte, 2007). Bertalanffy hoped that systems theory would serve as the new way of viewing people and could combine biology, psychology, physics, chemistry, and social sciences so we could take a stance of wholeness (Forte, 2007). Talcott Parsons developed a framework for combining the environment around us and human behavior (Forte, 2007). He included the important functional aspects of other systems such as: adaption, goal attainment, integration, and patterns of maintenance (Forte, 2007). Gordon Hearn took these ideas a

step further and explained there are living systems surrounding individuals, groups, and communities and those systems are where social workers do their work (Forte, 2007).

The systems theory examines how important it is to view each person as a unique product of what is around them and what is going on inside of them. The systems theory examines the important parallels of other disciplines and creates a framework for understanding the complex human involvement. This theory allows social workers to enhance an individual's environments as well as their relationships with other people in order to help them feel they are living their life to the fullest potential (Forte, 2007). This theory is important in understanding the participants in the Hospital to Home project because the individuals have many complex issues and components to their lives. To understand how they found themselves in this program we have to understand their psychological state, their physical health, and their environment before and after being homeless. Understanding this can help the employees at Guild Incorporated better serve their clients and recognize their needs.

Empowerment Theory

Empowerment theory attempts to use individual's positive behaviors, strengths, and helping abilities to induce positive change (Perkins & Zimmerman, 1995). Empowerment theory focuses on exploring people's capabilities and strengths instead of focusing on deficits (Perkins & Zimmerman, 1995). The intervention includes engaging in collaborative problem solving while developing knowledge and skills with professionals (Perkins & Zimmerman, 1995). The empowerment process can occur on the micro, mezzo, and macro level for individuals (Perkins & Zimmerman, 1995). The

theory suggests that individuals need to work with others to accomplish their goals and mostly to feel as though they are able to accomplish their goals.

I use empowerment theory as a researcher because the social worker and nurses of Guild Incorporated work to keep people in the community and collaborate with their clients to achieve their goals of being a healthy housed human despite their risk factors. In qualitative work the responses and outcomes are determined by the respondents. The respondents are given an opportunity to express their needs and personal experiences to be examined and possibly give rise to change in the program. The use of empowerment is important for qualitative work because it directly shows respondents that others are interested in understanding and helping them by providing their direct responses in the research.

Maslow's Hierarchy of Needs

The last theory that is incorporated into this research is Maslow's Hierarchy of Needs Principle. Abraham Maslow was a humanistic psychologist (Simons, Irwin, & Drinnien, 1987). Humanists view people's behavior as always trying to reach higher levels of capabilities (Simons et al., 1987). Maslow set up a hierarchic theory of basic needs where people do not want to reach the next level until the demands of the first are met (Simons et al., 1987). The very first needs to be met are the physiological needs which are the need for oxygen, food, and water (Simons et al., 1987). The second level of needs are the safety needs and feeling of being secure (Simons et al., 1987). The third level of needs to be met are of love, affections, and belongingness (Simons et al., 1987). The fourth level of need is the need for esteem which involve the need for self-esteem and respect from others (Simons et al., 1987). Finally, the last need to be fulfilled is the

need for self-actualization or a need to be what they were born to be (Simons et al., 1987). Although, we can find examples in the literature of people crossing needs and not following this pattern I use this theory because Guild Incorporated often makes it a priority for people to be housed and secure before they can work on their mental health. I also use this theory because when examining the answers of participants we may see differences in the responses based on how long they have been housed.

Methods

Research Design

I will use qualitative research for this project. Qualitative research uses data through narratives, descriptions, words, and pictures (Monette, Sullivan, & DeJong, 2011). Goals of qualitative research are to reach for understanding by finding collective ideas with in the data beyond numbers to in-depth theories and common themes (Monette et al., 2011). Other researchers have explored the Hospital to Home program but they have used quantitative methods to understand if the goals they put forward are working. I am interested in how the respondents feel the program is working for them and how they feel they are faring since entering the program. Using an interview style will help me create meaning for the respondents replies (Monette et al., 2011).

The interview questions (Appendix A) are designed to be open-ended to capture the participant's feelings and experiences as best as possible. There are timeframe questions like "how long have you been with Guild Incorporated," that are meant to get a sense of how connected potential participants are with Guild and how long they have had access to particular resources. Other questions involve asking the respondent about

mental and physical health changes or barriers for change. One question asks participants to discuss new issues that have come up since they have been housed (if they are housed). This question is important to understand because people's needs change as they can successfully access more resources that improve the quality of their lives.

Sample

The participants of this study are adult men and women of the program Hospital to Home apart of Guild Incorporated. Potential participants will be referred to Guild Incorporated through Regions and other mental health organization in St. Paul Minnesota because they meet specific health qualifications. The health qualifications the respondents will meet are having a physical illness, being chronically homeless, and using the emergency room more than five times in the past year. Once they are voluntarily admitted into the program they work with a multidisciplinary team of mental health practitioners and nurses to get housing and meet the specific needs of each individual such as: receiving medication, getting a primary doctor, etc. There are 25 people in this program and I hope to interview at least 8 of the 25.

I will recruit the participants through the Hospital to Home's social worker and nurse. They will be informing the possible participants that they can call or e-mail me if they want to participate and they will give them an information sheet (Appendix B). The information sheet explains what the research project is about, the risks and benefits, and the procedure for how I will record and store the information. The information sheet will explain confidentiality; their identity will be kept anonymous and they will be tape recorded but if they are uncomfortable with being recorded I will type their answers into a word document. Individuals apart of the program may be excluded because potential

participants have complex issues. All of the participants are considered capable of living in the community. If the social worker, nurse, or program supervisor knows the potential participant is actively suicidal, actively homicidal, or is in a crisis unit the individual will not be invited to participate in the study.

They will be given a $5.00 gift card to Rainbow at the end of the interview. After they are given the information sheet they can choose to contact me if they are interested. Most of the people from Hospital to Home will be given this opportunity which is considered a convenience sample (Monette et al., 2011). Guild Incorporated has given permission to conduct this research (Appendix C). Upon the participants calling, I will recite a telephone script (Appendix D) to tell each person that I am a graduate student from St. Catherine University and I want to conduct an interview with them on their experience in the program. I will tell them their identity will be kept anonymous and their answers will be used in a research paper. The participants can meet me at Guild Incorporated or I can meet them in a more comfortable place, like their home. The interview questions (Appendix A) will be used for every participant but I will ask some questions which are more exploratory so they can expand on their answers.

Protection of Human Subjects

Before beginning this project St. Catherine University Institutional Review Board will review and approve my proposal. This research will be conducted under the supervision of Dr. Catherine Marrs Fuchsel, Assistant Professor in the School of Social Work at St. Catherine University and University of St. Thomas. This study was approved by Guild Incorporated and they signed a letter of cooperation (Appendix C). I will ensure the protection of each participant throughout the study. Individuals apart of the program

may be excluded because potential participants have complex issues. All of the participants are considered capable of living in the community but if the social worker, nurse, or program supervisor knows the potential participant is actively suicidal, actively homicidal, or is in a crisis unit the individual will not be invited to participate in the study. While speaking to them on the phone the participants will either agree or disagree to the interview. When we meet I will review the consent form which also contains extra information about the study (Appendix E) which describes the research project and will give them a chance to ask any questions. The consent form explains how long the interview will last, were we will meet, the risks and benefits of the study, and confidentiality. I will explain that they can choose not to participate at any time and will answer any questions and concerns before the interview. Once they understand the project in full they can choose to sign the consent form if they want to participate. Even after they sign the consent form, if they feel they do not want to continue, they can choose to retract their interview.

The interview will be kept confidential by providing a closed conference room at Guild Incorporated to conduct interviews or they can choose to invite me to their homes and the interview will be conducted privately. I will be recording the participant's interview with an audio tape-recorder. The Information will be stored on a private computer and once I have transcribed the interview the audio tape will be destroyed. If the participant chooses not to be recorded I will type their responses to the interview into a word document. To further protect the participants, I have done no further secondary research into their background and have no information on the specific issues they face like mental illness or substance abuse. No one except me will have access to my private

computer. Participants will be given a Rainbow gift card after their interview is done. Participants will be given a list of resources (Appendix F) in the event the participant may experience emotional distress and/or start experiencing a crisis. Along with the resource list the interview will be terminated and the participant will be advised to call their social worker.

Data Collection

The participants will answer the questions from the interview and I will record what they are saying on a tape-recorder. If they decide they do not want to be recorded I will type their responses into a Word document. After completing each interview I will carefully transcribe each interview into a Word document without writing any identifying information about the participant. I will use content analysis to pull out the related ideas and I will organize this information accordingly. Content analysis examines words or phrases that are found throughout interviews which can be organized in a category or theme (Monette et al., 2011). Based on the themes that could be found I will use that information to compare this to the literature review, make predictions, and make suggestions for future practice and research.

Strengths and Limitations

This study will examine individuals who have a chronic health issue, who are chronically homeless, and who use the emergency room frequently. Studying individual experiences with mental and physical health with homelessness is important to understand how they interact with each other. There is research on how these illnesses impact emergency room use but there is little research on programs that address this. A

strength of this research is that no qualitative work has been done with the individuals of this project. This is qualitative research can access of the participant's feelings and thoughts because there are open-ended questions. This research could provide information for others to set up comparable programs for people in similar circumstances. This research could be useful for this program to expand with more knowledge of how participants feel and what they need.

One of the limitations in this study is the small sample size, therefore, it is more difficult to generalize to the larger population. A small sample size may mean that the person's who were interviewed will not be true representations of others who are chronically homeless, have physical illness, and use the emergency room excessively. Because qualitative research provides us with detailed information about one person it may not transfer to other people. Another limitation to this data is that I will be finding themes and related ideas and I am a biased person. This sample is from Minnesota and there may be some unique challenges people face that motivate them differently than if they lived in southern state. Interviewing people who have mental illness and physical health issues is another limitation. Although all of the participants are not considered vulnerable adults mental illness can interfere with respondent's answers in the interview. Potential participants will be asked about challenges concerning health and barriers in life they are facing and this could bring up sensitive and emotional responses. In the event that a participant becomes too distressed over the interview material the interview will be terminated and the individual will be given a list of resources (Appendix F).

Findings

In this section, the characteristics of the participants will be discussed as well as the themes of the participant's responses. In order to protect the participant's identities and preserve confidentiality the participants have been labeled by the letters "A" through "G". The participants reported on their experiences with housing, Guild Incorporated, and their quality of life before and after entering the program. The major themes of the participant's responses were found, they are: Guild Incorporated's Service, which included medication help, doctor visits, housing, and participants feelings about the program; shelter conditions; issues once people were housed; issues leading to homelessness; and fulfilling goals.

Characteristics

There were a total of seven participants. Of those seven participants six were men and one was a woman. All of the participants have been with Guild Incorporated for under two years as the HHP is new. All of the participants met the qualifications for the Hospital to Home Program which means that they are chronically homeless, they have a chronic health condition, and they have been in the Emergency room five or more times in a year.

Guild Incorporated's Services

Participants were asked to describe their time with Guild Incorporated. They were asked what things Guild has helped them accomplish, what they feel they still need help with, and what kinds of physical and mental health changes they have experienced since being in the program. All of the participants stated that Guild Incorporated's

employees had helped them with finding housing, getting medication, and making sure they were being seen by the correct doctors for their physical and mental health issues.

Medication Help. To be eligible for the HHP participants must have a chronic health condition and have used the Emergency room more than five times in a year. This would indicate that many of the people in the program will need help with medication management. The participants often stated that they had mental and physical conditions that they struggled with. Participant C described what the Guild Incorporated team had done for him and he stated, "I have taken my medicine like I should. I have more than one ouchie (problem)." He indicated he needed help with multiple issues and the team has provided that help. Participant A spoke about disliking medication but Guild's team helped him through that. He stated:

> The hospital to home team is a really good team. They helped me get my prescription together and they actually stayed on my case about taking them (laughter). Because I am not a medicine person. I don't like pills or anything like that. They are on me about that, they help me mange my blood pressure and my diabetes.

Every participant spoke about Guild's team helping them with medication issues. Participant G also spoke about how he felt about medication. He discussed issues of remembering to obtain and take his medication.

> I feel better because I am maintaining my medicine. At first I wouldn't take my medicine or nothin' so they taught me how to take my medicine and they

> monitored and they give it to me every week so I don't have to go out to the doctor and get it. They set it up for me and everything. I like that.

Doctor Visits. A consistent topic that was brought up in the interviews was the importance of getting to and making doctors' appointments as well as communicating with them. Due to the complex and serious needs of this population it seems that the participants need to see multiple kinds of doctors to address the difficult issues they are experiencing. Participants were not directly asked questions related to types of mental or physical health they experienced, however, participants shared types of mental and physical challenges. For example, participants reported experiencing Diabetes, Posttraumatic Stress Disorder, Chemical Dependency, Major Depression, Asthma, and Renal Failure. Many of these mental and physical health concerns would be addressed by different doctors and could require things like specific medication instructions, consistent blood sugar testing, and possibly treatment programs. Participant F spoke about how he feels about managing doctors' appointments, "like making doctors' appointments because I can't make doctor's appointments on my own. I don't understand that well. But I am so glad that somebody is here to help me to do these things. So that's a blessing." Participant A spoke about how happy he was that Guild's team knows so much about different health issues and they can advise him on them. He stated:

> …And they don't do it in a bad way or anything like that. They make sure that you go and see certain doctors and make sure nothing's going on with you like depression or anything like that. They make sure you get to these doctors and appointments. And they put you in contact with the right people.

One participant spoke about how frustrated she felt when she tried to get medical attention. She stated that they often did not listen to her describing her symptoms and she felt they did not take her seriously. She feels like having a member of the team with her at appointments aids in helping the doctors understand what is going on with her. She described: "They really don't like to listen to me until I take my nurse with me and then she be like. Well, she tried to tell you this IS the problem and they just don't seem to listen to me. Doctors can be stupid."

Housing. In order for participants to be admitted into the HHP they are required to be chronically homeless. All of the participants that were interviewed were currently housed and all of them stated that the Guild Incorporated team were responsible for helping them find housing. The housing experience and what it was like to have Guild Incorporated support them was a common theme in the interviews. Participant F discussed being in a shelter and what it was like to be housed after experiencing homelessness for a long period of time. The participant reported: "like they say, there's nothing like home. And that's a great feeling when you got a place. I can say, I can go home. You don't have to spend your day at Dorothy day or Mary hall. That's a blessing that I have." Participant D had a similar reaction as participant F. He described how he felt about having a place of his own:

> It's been good I actually feel like I am living again. I don't have to stress about where I am going to lay my head at night. You ain't got a place to live for a while and then all of a sudden you have a place and it's like night and day. It's been good. I feel like I am living again. I feel like I have a purpose.

Participant A had the same positive feelings as participants F and D. All participants described feeling happy in a stable housing situation. Participant A provided many of his answers with stories about his life. When answering the questions about his experiences of being in a place of his own, he stated:

> When I first came in to sign this paperwork and they gave me my keys I came here and I had nothing in this apartment and I went into the bedroom and I laid down and I took my coat off and everything. And I went *home.* And I went to sleep. It was wonderful. That's the best sleep I had on the floor in my whole life. And, you know, I said my prayers and I was very thankful. I did have a few things that I brought with me uh, I put in the refrigerator. I remember (laughter) it was a mountain dew, a bag of potato chips, and a half a subway sandwich. And I was eating, this was a celebration (laughter) I laid up against the counter and ate standing up, I didn't care. That was one of the best meals I had in my life.

Participants Feeling about the Program. Another theme that arose during the interview was participant's feelings about the Guild Incorporated's team. The Hospital to Home team has one nurse and one social worker that help the participants. All the participants had positive things to say about the Hospital to Home team. Participant D said, "The people here at Guild are just angels from heaven. The things they do for you are amazing. I didn't realize there were people out there who actually care like that. It's been good." He spoke in the interview that he was close to death for an extended period of time and that he was added to the Hospital to Home team when he was very ill. He spoke about this:

> I own my life to them for what they did for me. I was on my way out. My diabetes was off the hook and my blood sugar was over 600. I mean I was hospitalized four times before I met these guys I wasn't living a quality of life and now I am.

Other participants had similar responses. Participants felt a sense of gratitude as though if they were not with the Hospital to Home team they would be dead. Participant F shared that she was in a shelter and she was sick and thought she was going to die. She stated:

> This program is a God sent to me. I was telling (the team's nurse) I probably would have been dead this year because I was getting sicker and sicker. I didn't have no insurance or nothing and they didn't give me no insurance until I went into renal failure and then they gave me health insurance and I was like whoa, you gotta be damn near dead for them to help you. And when they (Guild) came along I was like yes! I used to cry a lot and every time (the HHP nurse) talked to me I was crying. So, yeah it's a lot better!

Participant B stated that Guild Incorporated helped him and he also feels like he will continue to need their assistance. He stated, "I feel like Guild helped me out a lot. I feel without them… I definitely need them to continue on with my life." The HHP also made participants feel a sense of stability and normalcy. They shared that after long periods of chaos, Guild Incorporated gave them some peace. Participant E stated, "I feel a sense of stabilization. I don't have to walk the streets. I don't have to find somebody who will let me lay on the couch. It's been rough." This sense of stabilization makes others feel free and have hope for the future. Participant A described this experience:

> Well, I feel a level of freedom that felt lost to me. Um, I've never, It's weird… how can I put it onto words… The feeling that I have made me feel free made me feel like there's new world out there for me to conquer. Um, and there's a new world for me to appreciate.

Shelter Conditions

All the participant in the HHP experienced chronic homelessness. A theme that was found in the interviews was shelter conditions and their experiences with shelters while they were homeless. They described how difficult it was to stay there and participants reported to trying to get out of homelessness in the shelter system. Participant A stated to have a job while being homeless can be difficult because shelters dictate that to get a bed in the shelter individuals have to be at the shelter by a certain time otherwise they will not let them have a bed. This can be complicated when someone is working during the hours that do not line up with the shelters policy. He said:

> They are like well you should be happy that you have a roof over your head when you come in. Or um. And those that can't afford a bed or a dorm. You know. They have to get back at a certain time, they have to go through the programs that is there. Whether they want to or not. And some guys they are working these temp jobs and they don't get to come back when they want them to come back early enough to get the bed. And it's a terrible feeling to work all day and don't have no place to lay your head.

Participant A also spoke about trying to have any personal belongings while living in a shelter. He spoke about how difficult it is to own anything and to have any privacy there.

He stated, “With the shelter and all, the way they do things is you only have, you gotta take everything with you every day.” Participants also discussed that living in a shelter felt confining and much like they were in an institution. Participants often felt like they were in prison. Participant D spoke about living in a shelter, he stated, “I’ve never had my own place. More like being institutionalized in facilities. It was like here’s your room and go tuck yourself away.” Participant G also spoke about the shelter conditions. She spoke about how sick she was throughout the interview. When she was staying in a shelter was when she stated she was the sickest she has ever been. She said, “I was in the shelter for like a year. I was sick all the time and the food that they were serving I guess was making me sick.”

Issues Once People Were Housed

A theme that emerged in the interviews was participant’s challenges once they were housed. Participant C reported that he had never had a stable place to live. Once he was in an apartment of his own he found it to be intolerable. He said:

> At first it was unbearable. I am used to outdoors. When you go to four square walls you have to make some serious adjustments. Quit staying drunk every day and go live in some place warm and pay bills which is something I wasn’t doing when I met them.

Other participants reported having moved from apartment to apartment. They stated that they had some difficulty maintaining housing. Participant B stated that he was being asked to leave his place but he did not state why. He stated his feelings about being evicted: “Right now it’s a bad time for the landlord to be telling me that I need to move

along. It's a bad time right now. Because it's real cold outside. I don't have the money to move." He was distressed talking about where he was going to move and wondering if he was going to be homeless again.

While I was at Participant A's residence, our interview was interrupted by a friend of his knocking at his door. This friend entered his home and went into Participant A's front closet which was full. He stated that he allowed his homeless friends to store their things at his house. His friend then proceeded to make himself some food in participant A's kitchen. He proceeded to tell me about how his friends allowed him to store some of his baking equipment when he was homeless. He feels a responsibility to pay this favor back to the community. He stated:

> And I had some, because I ugh bake, I had him keep some of my baking equipment at his house. And um I am very thankful so I always think to pay it forward. And I am glad that is a trait that my mother put into me. Is to pay it forward. A lot of times um you can't pay it back but you can pay it forward. You know it keep everything rolling. So that's what I do.

He feels like allowing people to store things at his house is a favor to the homeless and his friends. Although he feels like this is his responsibility, people letting themselves in and out of his house could cause an issue with his landlord. This could also lead to other issues like allowing people to stay with him which would break his lease.

Issues Leading to Homelessness

All of the participants have different and complex reasons as to how they ended up on the Hospital to Home team. Some participants spoke about some issues and

situations that lead to difficult times in their lives. Participant A spoke about a divorce he went through which lead to him couch hopping with his friends. He stated:

> But when the divorce hit, it hit me really hard. It hit me hard financially, it hit me hard emotionally. Um, it was hard because my daughter was 4 at the time and she was a daddy's girl and I have always wanted to be a father. So I always wanted to be there and stuff. And all of her development and it became very hard. And um, everything started spiraling out of control and I was living with a friend and his landlord didn't approve of it so I ended up sleeping at work.

Participant C spoke about two different issues he experienced that lead to his involvement with Guild Incorporated. He spoke about his time in prison and how it led to his time struggling with homelessness. He said:

> I went straight from prison to the streets and that's exactly what they do. They don't send you home to the kinfolks especially when you ain't got none. I ain't from here so. I love MN, no better place in the world. It's tough when you come out of prison. I was in prison in Nebraska so when I got out of prison I went here. I wasn't going back to prison in Nebraska. It's a shit hole, all they got is prisons.

He also spoke about his struggle with chemical dependency, "My life was drunk behind a dumpster all the time. You know, you don't care. All you care about is when you're going to get your next drink. Then when you get sober, shit, other shit matters." He stated that Guild Incorporated was a large influence in him getting sober.

Fulfilling Goals

Participants spoke about things they want to accomplish in the future. Participants who were housed for longer periods of time talked about wanting to find a job, wanting to find a partner, and wanting to get a license and car. Participant D spoke about wanting to go back to school:

> I want to further my education. I ain't got much of an education as it is but I think there's going to be some barriers where I am going to have to struggle through and get more education. I want to get back into the work force and be a part of society. I am hoping that it won't be that hard and I'll be able to slide in and move forward.

Participant A and B are interested in getting a job. Participant A discussed his long history of being employed and feels like he has skills to offer. He said:

> Um, basically I am trying to. Basically, even though Guild has tried to send someone out to help me with it, I wanna get back into the uh, job field. I want to get into something that I can do without stressing anything out because I have bad knees and stuff like that. So, I am hoping they can get me into a career opportunity where I can use my talents and my skills, my skill level. Ya know, to create a better income for myself.

Participant A also discussed wanting to start dating. He feels like he is in a healthier place where he can consider finding a partner. He stated:

> And I think um I need to get out and start dating more. But I date with, um, the mindset that of is this a person that I can be more compatible with and somebody

that can come into my home. And still feel at home and I don't feel on edge when she's in my home.

Participants of the HHP were interviewed and asked questions about how they feel about their quality of life, what things Guild Incorporated has helped with, and about their housing situations. The major themes of the participant's responses were found, they are: Guild Incorporated's Service, which included medication help, doctor visits, housing, and participants feelings about the program; shelter conditions; issues once people were housed; issues leading to homelessness; and fulfilling goals. Overall, participants felt grateful for Guild Incorporated and felt their mental and physical health had improved since being in the program. There were similarities found within the literature review and in the interviews.

Discussion

A program called the Hospital to Home Program (HHP) has been created for people who have at least one chronic health condition, have been to the emergency room five or more times in the previous year, and have a history of chronic homelessness. Participants of the HHP were interviewed and the transcripts were analyzed for themes. A number of similarities were found within the findings of the interviews and the literature review. Among the topics compared and contrasted were, participants having both a chronic physical illness and a serious mental illness. Findings in this study coincided with Sun's (2012) recommendations to helping the chronically homeless with co-occurring disorder, individuals following Maslow's hierarchy of needs in terms of having goals, individuals struggling in their new housed environments, and participants being successful in the hospital to home program.

Having Co-Occurring Illnesses

Many participants spoke about having a chronic medical condition as well as having a serious mental illness. Individuals must have one chronic health condition to be admitted into the HHP. It was found that some of the participants, although not asked, volunteered the fact that they struggle with complex mental and physical illnesses that include: Diabetes, Posttraumatic Stress Disorder, Chemical Dependency, Major Depression, Asthma, and Renal Failure. The idea that people who are chronically homeless also struggle with multiple mental health and physical issues is consistent with the review of the literature. Jones, Macias, Barreira, Risher, Hargreaves, and Harding (2004) found that among 147 people with serious mental illness, 74% of them had one chronic health problem and 50% had been diagnosed with two chronic health conditions. This implies that those struggling with mental illness often will have another or multiple co-occurring disorders.

Housing

Similarities found in the review of the literature were recommendations on how to help house people who were chronically homeless and who have a chronic health conditions. Sun (2012) recommends the following: (a) helping the chronically homeless with co-occurring disorders are, (b) helping clients to transition easily from institutions to the community, (c) helping them apply for government entitlements, (d) linking clients with supported housing, (e) and helping them enter a program to assist them with their mental illness and/or substance abuse. All of the participants in this study were housed and stated that the things that had helped them the most were getting help with their medication and doctor's appointments, getting help with government assistance, and

helping find a place to live where they would be successful. This aligns with what the literature states about what has been successful with helping those who are homeless who have co-occurring disorders.

Issues Once People Were Housed

A theme consistent with the review of the literature is that participants who are chronically homeless experience issues once Guild Incorporated helped them find housing. Jost, Levitt and Porcu (2010) found that for people who were chronically homeless to be successful in housing they had to adopt to their surroundings in a home, discover the benefits of being housed, and to be ready to leave the streets. This was consistent with the interviews in that participants reported that they had some struggles when trying to adapt to living in their own place, participant C called it "unbearable." Participant C noted that getting used to living in four walls was difficult.

Maslow's Hierarchy of Needs

Participants who had been housed for longer periods of time had goals consistent with the Maslow's Hierarchy of Needs structure. Maslow's Hierarchy of needs was not discussed in the literature but is noted in the conceptual framework. There are five levels to Maslow's Hierarchy and each level describes needs to be met to becoming a self-actualized person (Simons et al., 1987). The very first needs to be met are the physiological needs which are the need for oxygen, food, and water (Simons et al., 1987). The second level of needs are the safety needs and feeling of being secure (Simons et al., 1987). The third level of needs to be met are of love, affections, and belongingness (Simons et al., 1987). The fourth level of need is the need for esteem which involve the

need for self-esteem and respect from others (Simons et al., 1987). Finally, the last need to be fulfilled is the need for self-actualization or a need to be what they were born to be (Simons et al., 1987). This direct path to meeting these needs in order is seen in the interviews when participants discussed goals they had. Participants who had been housed the longest and had their physiological needs met had goals in the third and fourth level of Maslow's hierarchy of needs. These participants spoke about wanting to go back to school, wanting to find a job, and wanting to find a partner.

Participants Feeling Successful

The review of the literature which stated that the HHP was meeting their goals with participants was consistent with the interviews stating that participants feel as though they are successful in the HHP. The participants spoke highly about Guild Incorporated and often stated that they felt they would be dead without them. The review literature stated that participants of the Hospital to Home program had a steady decrease in emergency room visits, participants increased their use of clinics and services as their health issues were now being addressed, and participants reported being more self-reliant (Wilder Research, 2012).

A review of the literature showed support for multiple ideas found in the interviews. Findings in this study matched with Sun's (2012) recommendations to helping the chronically homeless with co-occurring disorder, individuals following Maslow's Hierarchy of needs in terms of having goals, individuals struggling in their new housed environments, and participants being successful in the HHP. This implies that the HHP's social worker and nurse are helping people in a way that is consistent with the

recommendations found in a review of the literature and that the HHP's participants feel they have a better overall quality of life due to the HHP.

Strengths and Limitations

This study was designed to elicit the HHP perceptions of the quality of their lives after enrollment and the barriers and/ or issues that may occur as people access services in the program by interview. The broad goal of the research question was met in that participants reported what they thought of the program, what they need out of it, and how they feel about the quality of their lives. Social workers can benefit from this research because it may provide more of an understanding of what clients who are chronically homeless, have a chronic health condition, and who are using the emergency room for than five times a year are experiencing. This study showed lived experience from a vulnerable population and interviews from this population can be difficult to obtain. Another strength of this study is that it pays attention to a population that often does not get paid attention to. Researchers may avoid paying attention to this population because of the complicated mental and physical health issues which make research that is generalizable difficult. It is important for social workers to meet standard of practice by paying attention to a population that needs help.

There were many strengths of this study however, limitations must be examined. There were themes and similarities between participants but experiences were unique to each individual and therefore cannot be generalized. Participants were recruited through Guild Incorporated's staff and although I specifically stated that I was not affiliated with Guild Incorporated and their answers would not affect their services, they may have felt they could not express any dissatisfaction with the program. Participants were only asked

approximately ten questions and I found that many kept their answers short. It is possible that participants did not respond to a structured interview. People often tell detailed stories about their lives in a narrative way rather than in response to short questionnaires. To get a better understanding of their lives I would have asked the participants more questions. There are more participants in the Hospital to Home Program and only seven responded to the Information Sheet so, the sample size was small.

Implications for Social Work Practice

Given the knowledge gathered from the literature review and findings of this research, it is important to understand how chronic health condition, mental illness, and chronic homelessness creates complex barriers which requires multifaceted treatments and community resources. Social workers can assist people in these situations by learning about how these issues interact and create many obstacles. The social worker and nurse of the hospital to home team work to help participants manage and treat their diverse issues. They understand participants need a variety of services like finding housing, assisting in medication management, going to doctor's appointments, helping with government forms, and assisting in becoming employed.

With the knowledge obtained by the findings of this research it is important for this population that social workers listen to what the client needs. Although there were themes among the services offered, it was clear that the social worker and nurse of this program aided each participant differently according to their specific needs. Some participants needed help with understanding doctor's directions, others needed help obtaining medication as they struggled to walk, some needed specific services gear towards their families.

Implications for Policy

The hospital to home program is a new service being offered in Minnesota. It is important for addressing the complex needs that chronic health conditions and homelessness deliver. The program is targeted at reducing emergency room visits and it has been successful in the short time the program has been around. It seems clear that the participants of the hospital to home program are those that frequently fall through the cracks of system. The participant often commented that they know they would have been dead if this program had not helped them. The program has been successful in all of its short-term goals, it saves the state money by reducing the rate of emergency visits significantly, this research shows the participants are grateful they are being helped, and mostly it seems like they are saving people's lives. This program will needs grow at Guild Incorporated and needs to be implemented in other cities.

Implications for Future Research

Future research should focus on what is happening to people before they end up in the Hospital to Home Program. There was a theme observed in this research which involved the situations the participants experienced which led to some of their struggles. Researching people struggles leading to entering the program could provide useful information for starting more preventative programs to prevent extensive suffering.

Future research should focus on the correlation between early childhood experiences between mental health, physical health, and homelessness. Understanding how these situations develop can help professionals develop services. These services can

target specific issues to prevent them from compounding and becoming chronic and lifelong.

A gap in the literature that was found in this research study is the issues that occur after moving into a place of their own. People who are chronically homeless clearly struggle to maintain and/or find housing. A participant was being evicted at the time of the interview and another participant reported that he had trouble sleeping indoors as he had been sleeping outside for most of his life. This information could be useful in preventing eviction and problems once a participant is housed.

Another study could be done with these participants to gain more knowledge. Future qualitative work could be done with these participants and a more open ended questions such as, "tell me your life story" could allow more freedom for the participant's perspective. Participants may feel more comfortable answering this question versus a structured interview as a structured interview may not capture the events in their lives that are significant for that individual.

Conclusion

Those with chronic mental health condition, chronic homelessness, and chronic use of the emergency room are a complex population with diverse needs. The HHP was designed to address these unique needs and provide individually tailors services. Not only have the qualitative goals been met but this study shows that the participants feel as though their quality of life has greatly improved since entering the program. It is the hope that with this research and more like it the HHP will grow at Guild Incorporated and be a guiding tool in providing services to this population.

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APPENDIX A
Interview Questions

1. How long have you been with Guild Incorporated?
2. What things has Guild Incorporated helped you with?
3. What are some things you still need help with?
4. Can you describe any physical or mental health changes since being in this program?
5. If you are housed, how long have you been housed and can you describe that experience? (If "no" continue at question 8)
6. Once you were housed, what did that look like and can you describe those new experiences? (Go to questions 8)
7. If you were ever housed, can you describe that experience?
8. How do you feel your overall quality of life is now that you are in this program? Can you describe those feelings and thoughts?
9. Can you describe any barriers you may still be experiencing to living a happy healthy life?

Appendix B

Information Sheet

My name is Britani Lalone and I am a Master's student in the School of Social Work under the direction of Dr. Catherine Marrs Fuchsel, PhD., LICSW from Saint Catherine University and the University of Saint Thomas. I am conducting a research study to explore how you feel about the Hospital to Home program. I am interested in learning how you feel about your experience with Guild and what barriers are still in front of you. I hope that what I learn from this study will help social workers and any mental health providers understand that when people struggle with complex issues it takes many resources and on-going support for people to live and maintain the life they hope for. I would like to interview any participant from the Hospital to Home Program.

I am inviting you to participate in an interview about your experience with this program. I will be conducting the interview at Guild Incorporated in a closed room or at your home if you choose. I will set up the time and day for the interview depending on what is best for you. If you agree to participate, I will ask you if you understand the information letter, if you have any questions, and if you agree to take part in the interview. You will then have to sign a letter of consent. This study is voluntary and you may choose to stop participating at any time. If you choose not to participate in this study, it will not affect the services you receive from this agency. You may also choose not to answer any question. If you feel distressed and/or are in a crisis, you will be given a resource handout and will be advised to contact your caseworker.

In the interview, I will ask you about your experiences with Guild Incorporated. I will ask you about what you have gotten from Guild Incorporated and what you feel like you still need help with. I am interested in your experience with housing and if you are experiencing any new barriers for being happy and healthy.

You will be given a $5.00 Rainbow gift card for participating.

This study may help Guild Incorporated understand what you are feeling about their services and the issues you may still be facing. Furthermore, the interview can provide information on how these kinds of services have affected their participants. The information from this study will be published in my major project through Saint Catherine University and the University of Saint Thomas. Your name will not be used to identify you and information will be stored confidentially.

The interviews will be audio recorded and stored anonymously or if you choose not to be recorded Britani will type as you are talking. You will have the right to ask for the interview to stop. The information will be anonymously saved to a personal computer. The audio recording will be transcribed into a word document and saved confidentially. The data will be kept until April 30, 2014 and all reports and notes will be shredded.

If you are interested in participating in this study please feel free to contact Britani Lalone.

Contact information:

Britani Lalone

APPENDIX C

Letter of Cooperation for Research Project

Institutional Review Board
St. Catherine University
St. Paul Campus
2004 Randolph Avenue
St. Paul, MN 55105

RE: Hospital to Home

Lead Researcher: Britani Lalone
MSW Clinical Research Student
St. Catherine University and the University of St. Thomas
School of Social Work; Joint Program

Student Advisor and Chair of Research Project:
Dr. Catherine Marrs Fuchsel, PhD., LICSW
St. Catherine University and the University of St. Thomas
School of Social Work; Joint Program

To Whom It May Concern:

We have agreed to assist Britani Lalone in recruiting participants for her research project. Britani Lalone's research project will be a study on the experiences the participants of Hospital to Home. The research will be qualitative in nature and will seek to answer the question: What are the experiences of the participants of Hospital to Home and what barriers and/ or issues may occur as people access services in the program by interview? In order for her to recruit participants, we will allow the Hospital to Home's social workers and nurse to distribute an information sheet and to inform the potential participants that Britani will be calling them. Britani Lalone will call the participants from a list of phone numbers we give her.

They can inform Britani Lalone via telephone if they want to participate or we will inform potential participants to contact Britani by telephone or by email if they are interested in the research project. We will inform the participant's that they will give their written consent to participate in the research project after Britani Lalone has answered all of their questions. Britani Lalone will make it clear to potential participants when she speaks to participants on the phone or by email that any of the information they share during the research project will be kept confidential to the full extent permitted by the law.

Britani Lalone will make it clear to potential participants that their participation is entirely voluntary, and the information they share in their interviews with Britani will only be used for research purposes. Britani Lalone will also make it clear that research

participants' names will not be identified on the audio tape and will be stored on a private computer anonymously. If the participant does not want to be recorded Britani will type the participant's responses on a Word Document on her private and locked computer. The audio

Britani Lalone will make it clear to potential participants that they are free to refuse to participate in Britani's research project and that this will not affect their relationship to the organization in any way.

Sincerely,

_____ _____

Signature and Title Date

_ _____

Print Name

Appendix D

Telephone Script

My name is Britani Lalone and I am a Master's student in the School of Social Work under the direction of Dr. Catherine Marrs Fuchsel, PhD., LICSW from Saint Catherine University and the University of Saint Thomas. I am conducting a research study to explore how you feel about the Hospital to Home program. I am interested in learning how you feel about your experience with Guild and what barriers may still be in front of you. I hope that what I learn from this study will help social workers and any mental health providers understand that when people struggle with complex issues it may take many resources and on-going support for people to live and maintain the life they hope for. I would like to interview any participant from the Hospital to Home Program.

I am inviting you to participate in an interview about your experience with this program. I will be conducting the interview at Guild Incorporated or at your home. I will set up the time and day for the interview depending on what is best for you. If you agree to participate, I will ask you if you understand the information letter, if you have any questions, and if you agree to take part in the interview. If you choose to participate, you may sign a consent form to be eligible for the study. This study is voluntary and you may choose to stop participating at any time. If you choose not to participate in this study, it will not affect the services you receive from this agency. You may also choose not to answer any question. If you feel distressed and/or are in a crisis, you will be given a resource handout and will be advised to contact your caseworker.

In the interview, I will ask you about your experiences with Guild Incorporated. I will ask you about what you feel you have gotten from Guild Incorporated and what you feel like you may still need help with. I am interested in your experience with housing and if you are experiencing any new barriers for being happy and healthy.

This study may help Guild Incorporated understand what people are feeling about their services and the issues they may still be facing. Furthermore, the interview can provide information on how these kinds of services have affected their participants. The information from this study will be published in my major project through Saint Catherine University and the University of Saint Thomas. Your name will not be used to identify you and information will be stored confidentially.

The interviews will be audio recorded and stored confidentially or if you choose not to be recorded Britani will type as you are talking. You will have the right to ask for the interview to stop. The information will be confidentially saved to a personal and locked computer. The data will be kept until April 30, 2014 and all reports and notes will be shredded.

Contact information: Britani Lalone

APPENDIX E

Research Consent Form

Introduction:

You are invited to participate in a research study investigating your experience in the Hospital to Home Program. This study is being conducted by Britani Lalone, student in the School of Social Work Program at St. Catherine University and the University of St. Thomas, under the supervision of Dr. Catherine Marrs Fuchsel. You were selected as a possible participant in this research because you are in the Hospital to Home program. Please read this form and ask questions before you decide whether to participate in the study.

Background Information:

The purpose of this study is to discover your experience in the Hospital to Home program and the barriers and issues you have had as you progress with Guild Incorporated. Approximately 8-10 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to answer approximately 10 questions related to your experiences with Guild Incorporated. This will be a 30-minute to one-hour interview and you will agree to be recorded on a computer anonymously that will be used for this research only, agree to allow the information to be presented to the public in a non-identifying way, and agree to allow Dr. Catherine Marrs Fuchsel to review the data and transcript of the interview for a reliability check. The interview will take place in a room which will be available for the interview at Guild Incorporated or at your home. This study will take approximately one hour of your time.

Risks and Benefits:

The study has some risks. Due to the programs requirements of having a chronic medical condition and have significant history with homelessness, this interview may bring up strong emotions. If your feelings become too overwhelming, you may ask to terminate the interview early and you will be given a resource sheet of contacts if you need counseling or crisis services.

There are no direct benefits to you for participating in this research but you will receive a $5.00 Rainbow gift card for participating.

Confidentiality:

Any information obtained in connection with this research study that could identify you will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. This group data will be presented at Guild Incorporated.

I will keep the research results in a password protected computer in my home and only I will have access to the records while I work on this project. If you choose not to be recorded I will type your responses into a Word Document and it will be saved confidentially on my computer. Dr. Catherine Marrs Fuchsel will help analyze the transcripts. I will finish analyzing the data by April 30, 2014. I will then destroy all original reports and identifying information that can be linked back to you.

Voluntary nature of the study:

Participation in this research study is voluntary. You are also free to pass on some of the interview questions. If you choose not to participate, it will not affect your relationship with Guild Incorporated. However, if you choose to pass too many questions your interview may not be used.

Contacts and questions:

If you have any questions, please feel free to contact me, Britani Lalone. You may ask questions now, or if you have any additional questions later, the faculty advisor, Dr. Catherine Marrs Fuchsel can be reached at 651-690-6146. She will be happy to answer any questions you may have. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact John Schmidt, Institutional Review Board Assistant of the St. Catherine Institutional Review Board, at (651) 690-6203.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time and no further data will be collected.

I consent to participate in the study and I agree to the audiotaping of my interview.

_____

Signature of Participant Date

_____

Signature of Researcher Date

APPENDIX F

Crisis Resources

- If you are experiencing a crisis please call your social worker at **Guild Incorporated**
  (651) 450-2220
- **Crisis Connection- telephone counseling agency**
  (612) 379-6363

  -Available to all callers throughout Minnesota, free of charge
  -Immediately accessible
  -24 hours a day
  -365 days per year
  -Confidential
  -Able to respond to any problem
  -Delivered by skilled counselors

- **Community Outreach for Psychiatric Services (COPE)**
  (612) 596-1223

  When a severe disturbance of mood or thinking threatens a person's safety, call Hennepin County's COPE. If needed, COPE will arrange an emergency evaluation for inpatient psychiatric services. This service is available to all adults living in Hennepin County 24 hours a day, 7 days a week.

  COPE Professionals are able to:
  -Go where the person is
  -Handle immediate crisis
  -Provide clinical assessment

- **National Suicide Prevention Lifeline**
  1-800-273-TALK
  24 hour crisis for people in danger of harming themselves

- **St. Paul Crisis Services**
  (651) 266-7900
  Urgent Care for Adult Mental Health offers crisis services to help you or an adult you care about get through a mental health crisis.

  We provide:
  • Phone support 24 hours a day, 7 days a week

• Mobile crisis teams to meet you at a location of your choice
• Mental health crisis assessment
• Access to crisis psychiatry as necessary
• Chemical health screening
• Peer support
• Crisis stabilization services
• Family education and support
• Referral to community resources in Ramsey, Dakota and Washington Counties

- **Walk In Counseling Center**
  2421 Chicago Ave South
  Minneapolis, MN 55404
  (612) 870-0565

  -No appointment needed
  -No fees
  -No insurance necessary

  Hours:
  Monday, Wednesday, Friday: 1:00-3:00
  Monday-Thursday: 6:30-8:30

  1619 Dayton Avenue, #205
  St. Paul, MN 55104

  Hours:
  Monday, Wednesday: 5:00-7:00