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### Barriers to Maintaining Independent Housing Faced by SPMI Adults

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## Barriers to Maintaining Independent Housing Faced by SPMI Adults

by

Daryl Smith, B.A.

MSW Clinical Research Proposal

Presented to the Faculty of the  
School of Social Work  
St Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
In Partial fulfillment of the Requirements for the Degree of  
Master of Social Work

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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 finding of the study. This project is neither a Master's thesis nor a dissertation.

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## **Introduction**

Although mental illness in itself is not necessarily the cause of homelessness, the conditions of being poor and mentally ill places a person at a much greater risk for becoming homeless (Montgomery, Metraux, & Culhane, 2013). Substance abuse rates are also much higher among the mentally ill homeless population than the general public. Research indicates that substance abuse is used as a coping mechanism for dealing with mental illness and the condition of being homeless (Mahoney, 2006). The Wilder Institute indicates that 59 percent of homeless adults are affected by a serious persistent mental illness and that 27 percent have a drug or alcohol use disorder (2010). These factors also play an important role in the ability to maintain independent housing on a long-term basis (Schutt & Goldfinger, 2011).

The Minnesota Department of Human Services (DHS) defines a person with Severe Persistent Mental Illness (SPMI) as someone who meets one of the following three criteria: has been admitted to the hospital for care for mental illness two or more time within the past 24 months, has been hospitalized or received residential care for psychiatric treatment more than six of the past 12 months, or has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder with significant impairment in functioning and a written opinion form from a mental health professional. Further definitions provided by the Department of Human Services include someone who has been committed by a court as being mentally ill or someone who was eligible under these conditions but the time periods may have expired. An example of this would be that a person can still receive state benefits if they had been hospitalized for mental illness in the past and were continuing to receive care (2013).

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The Minnesota DHS defines homelessness as the absence of a fixed night time residence. An individual must lack a permanent place to live continuously for at least one year or at least four times in the past three years. Time spent institutionalized for mental health related issues or incarceration would not count toward this time in determining if someone is homeless. A person can meet the qualifications for a Household at Significant Risk of Long-Term Homelessness if they have recently become homeless and have previously been homeless for extended periods of time. A person may also be recognized as “at risk of homelessness” if they have been previously homeless and face homelessness upon being discharged from a correctional, medical, mental health, or treatment center and are lacking resources to pay for housing or are without a permanent place to live (2013). The Department of Housing and Urban Development (HUD) defines homelessness as a person residing in an emergency shelter, in places not meant for human habitation (cars, abandoned buildings, etc.), transitional housing programs, someone being evicted in one week without another residence, or someone being discharged from an institution or jail who has been a resident for 30 days and does not have identified housing (US Department of Housing and Urban Development, 2005).

These definitions provide a background to the population this research project is directed toward better understanding. The causes of homelessness for SPMI adults are closely related to the barriers that this population faces in maintain independent housing. An estimated 3.5 million people with SPMI live the majority of their lives in the community but many of these individuals live independently with no on-site support. It is necessary to better understand the factors that make up an optimal community setting and specific services that are most beneficial to help individuals maintain this level of independence (Newman, 2001).

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Studies directed towards housing and adults with SPMI have shown that having housing may contribute to a number of mental health outcomes including reduced costs of services. Certain factors like having neighbors with SPMI in settings with a smaller number of individual units within the housing have been attributed to greater stability from residents (Harkness, Newman, & Salkever, 2004). These factors are also related to difficulty with social inclusion faced by adults dealing with an SPMI. Social inclusion is understood as active participation in social, economic, educational, recreational, and cultural resources. SPMI adults who show improved social functioning are less likely to be hospitalized, experience a better quality of life, and report higher satisfaction with service providers (De Heer-Wunderink, Visser, Sytema, & Wiersam, 2012).

When viewing the issue of homelessness and mental illness it is necessary to understand the concept of “worthiness” and how service providers designate adults with a SPMI and categorize them for housing options. The policies and practices of human service organizations are part of what help professionals make decisions about placement for housing but these policies are not a clear set of rules. These professionals must try and reach an understanding of an individual situation and determine who will be placed on a list for potential housing and who may need a higher level of support. These professionals serve as a link between the client and the housing organizations. These organizations have directives on what criteria an applicant must meet for admission and are faced with a situation of many people applying for a limited number of housing options (Schneider, 2010).

Innovative approaches to the problem of finding housing adults with a SPMI include Assertive Community Treatment (ACT) for Homelessness and the Housing First approach. Assertive Community Treatment (ACT) involves the work of a multidisciplinary team with small

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client staff caseloads and has proven to be cost effective because of reduced utilization of hospital and emergency services (Coldwell & Bender, 2007). The Housing First approach seeks to address the problem of housing and/or homelessness even before addressing the problem of mental illness. The effectiveness of these approaches has not been widely studied but has shown promising results (Newman & Goldman, 2008).

While existing research suggests that there is a strong link between homelessness, mental illness and substance abuse it is not clear exactly how these factors result in a loss of housing. This paper will focus on obtaining a more in depth understanding of how different factors contribute to success or serve as barriers in maintaining independent housing. This information was gathered by interviewing professionals in the field of mental health and housing.

One of the foremost problems adults with a SPMI face in overcoming homelessness is finding affordable, safe and integrated housing of their choice (O'Hara, 2007). A general lack of housing has resulted in high rates of mentally ill persons who are experiencing homelessness. Studies indicate that an estimated 14 million Americans experience at least one episode of homelessness during their lifetime and of these 14 million 20 to 35% suffer from SPMI (Coldwell & Bender, 2007). General cuts in affordable housing and a lack of mental health programs aimed at preventing and ending homelessness mean this problem is likely to increase (O'Hara, 2007).

Research indicates that the ability of clients living with a SPMI to maintain independent housing is increased when given the right community setting. An individual's psychological well-being can be greatly influenced by the physical condition of their environment. In a situation where affordable housing is at a premium, many people from this target population do

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not have the luxury of finding ideal placement (Newman, 2001). Mental health professionals may have beliefs about what is and is not effective when providing housing for clients with a SPMI and these views may in turn affect the setting in which a person finds placement (Schneider, 2010).

Merely providing housing is not the only factor in promoting independent housing for mentally ill adults. Providing housing with beneficial neighborhood features has been linked to lower costs of mental health services for adults dealing with a SPMI. These features include well maintained buildings in neighborhoods with no outward signs of physical deterioration (Harkness et al, 2004). These factors coincide with O'Hara's findings that stress the importance of decent housing that is of the resident's choice. Adults with a SPMI face stigma and housing discrimination which can further limit available housing options (2007).

Mentally ill adults can face a difficult process of acquiring and further maintaining limited housing when lacking social support. Assertive community treatment (ACT) has proven effective in reducing the length and frequency of hospitalizations and increasing independent living skills for adults with a SPMI. This approach involves an interdisciplinary team with low client to staff caseloads leading to more intensive contact in a community based setting. Although these services can be more costly to administer than traditional case management, it has proven cost-effective because participants experience reduced hospitalization services (Coldwell & Bender, 2007).

## **Literature Review**

### **The Relationship between Mental Illness and Homelessness**



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Wilder research indicates that of the persons in Minnesota experiencing long term homelessness, nearly 59% have a mental illness (2010). The majority of adults with a SPMI who are homeless have been so for at least a year. Severe persistent mental illness can impede daily functioning in areas of self-care, social functioning, employment and education. Although having a SPMI is not, in many cases, the cause of homeless it does put people at a higher risk for this occurrence. (Montgomery, Metraux, & Culhane, 2013). Adults living with SPMI may experience difficulty maintaining housing as a result of mental health related symptoms, a lack of or loss of income, or overall difficulty in managing daily living activities (Sham, 2013).

Historically homelessness among mentally ill persons has been linked to deinstitutionalization. This movement started in the 1960's and has been defined by a majority of patients who formerly resided in psychiatric hospitals being discharged into community-based settings. The intention of this movement was that SPMI adults would receive psychiatric services within the community to address the needs that had formerly been met in the hospital. Communities at this time were not prepared to meet the needs of this population and many of these adults became homeless (Pearson, 2011). The idea that deinstitutionalization would lead to lower costs from public funding did not materialize because many of the adults who were affected faced an ongoing pattern of readmission to the hospital or prison. These adults lived only on the fringes of society when they did reside in a community setting (Thompson, 2012).

At the start of the deinstitutionalization movement there were not enough community-based services to assist the large number of SPMI adults who were in need. Some of the same problems that occurred during this movement still exist today. While hospital staff is available normally 24 hours a day to provide assistance, SPMI adults living independently are responsible to seek out care when they need it. A lack of discharge planning combined with a scarcity of

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resources or lengthy waiting lists for community based services creates a difficult process for adults with SPMI being discharged from hospitalization (Montgomery, et al, 2013). These individuals usually do not have the funding to regain their housing and end up being discharged without a place to live. The situation is made even more difficult if the person has physical health problems and a fixed income which may limit housing options in addition to mental illness (Sham, 2013).

Mental illness may function as a way of coping with the difficulties of life on the streets. Adults with SPMI who are experiencing disparaging conditions and are the objects of frequent negative attention may appear highly symptomatic but actually be functioning at a high level of independence and have an accurate grasp of reality. For some mentally ill adults the symptoms they are suffering from may create problems in dealing with social aspects of daily life. One schizophrenic adult reported that after going through a period of hearing and responding to both internal voices and the external voices of his co-workers, he ultimately quit his job. As the voices persisted this person reported that yelling worked as a means of making them more bearable. This patient presented in psychiatric appointments as becoming very agitated when he was responding to internal stimuli but responded in a calm manner when addressing or responding to staff members. This example illustrates how a person can present as being very disturbed but may in truth have a clear understanding of reality and be dealing with symptoms in the best manner they know (Schutt & Goldfinger, 2011).

Mental illness frequently is experienced in a cyclical pattern, meaning that those people who have a SPMI may go through periods of relative stability and periods of being more highly symptomatic with a higher need for services (Schutt & Goldfinger, 2011). Housing services aimed at serving SPMI adults have predominately been in treatment based settings such as group

homes. Studies indicate, however that this population prefers to live in housing that is independent and offers a non-restrictive environment. Research has shown that consumer choice is a necessary aspect of success in maintaining housing. Those adults with SPMI who are left without choices and who cannot find an environment that they find acceptable may wind up going between jail, institutions, shelters, and being homeless (O'Hara, 2007).

Schutt and Goldfinger's research does not support a link between consumer preferences and readiness for independent housing. In some cases, having a strong preference for independent living resulted in greater vulnerability toward housing loss. Consumer choice cannot be ignored however because this research also demonstrated that adults with SPMI who were placed in housing that was not of their preference retained this housing at lower rates than those who were placed in housing that was in accordance with their desire. Specifically adults dealing with SPMI who were strongly opposed to group home settings and were placed there based on perceived need often demonstrated behaviors that ultimately resulted in discharge (2011).

To properly address the problem of homeless among adults with SPMI it is necessary to focus initially on the problems they face with poverty and alienation. In many aspects the homeless mentally ill population does not differ greatly from the larger population of homeless adults. One of the primary reasons for homelessness is the lack of affordable and permanent housing. The deinstitutionalization movement has helped to emphasize that housing is not the only thing necessary to keep adults with SPMI off the streets and out of the hospital. To increase the ability of this population to maintain independent housing it is necessary to incorporate a variety of services from emergency to transitional and finally those to assist in stabilization (Thompson, 2012).

### **Barriers to Obtaining Housing Faced by SPMI Adults**

There are a number of factors that make gaining access to independent housing difficult for SPMI adults. A history of alcohol or other substance abuse disorder is frequently associated with the homeless SPMI population. Research indicates that 31 percent of the individuals accessing homeless services report a co-occurring mental illness and substance abuse disorder. These individuals often have physical health problems and are more likely to have a history of incarceration (O'Hara, 2007). The link between homelessness, substance abuse and mental illness is well documented but what is not as clear is if substance abuse is an actual cause of homelessness or in itself a coping method for dealing with mental illness and the condition of experiencing homelessness (Mahoney, 2006).

Studies have indicated that substance abuse combined with an SPMI diagnosis greatly increases the chances that a person will become homeless when compared with adults who are only dealing with mental illness. Adults with SPMI who have received treatment for substance abuse are also at a high risk for relapse which in turn can lead to homelessness. Individuals with a substance abuse disorder may reject treatment and lack motivation to change. This can be due, in part to lacking peer support in the recovery process and not establishing a connection to treatment (Schutt & Goldfinger, 2011).

One study conducted by Washington University in St. Louis found that nearly 80 percent of the homeless participants had been diagnosed with a drug or alcohol use disorder within one year prior to becoming homeless. Although not every person who abuses drugs and/or alcohol becomes homeless these factors do appear to be a strong contributor to a person's vulnerability to becoming homeless. Research has also found that experiencing homelessness is also related

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to increased substance abuse. In one study 30 percent of participants reported using more frequently after becoming homeless while the other 70 percent reported that their use stayed at the same level. This increase was linked by participants to increasing mental health symptoms such as anxiety and depression (Mahoney, 2006).

Adults faced with a severe and persistent mental illness face difficulty in finding independent housing because of a generally low income combined with a lack of affordable housing options. A person receiving Supplemental Security Income (SSI) would have to pay an estimated 113 percent of their income towards rent in an average market rent for a one bedroom apartment. For comparison a household is designated as having a very low income by federal government standards if they are paying more than 50 percent of their income for housing. Obviously a person cannot pay more for rent than they are receiving in income so for many adults who live with an SPMI their only option is some type of housing that is public and income based, meaning the cost of rent is based on one-third of their income (O'Hara, 2007). The Department of Housing and Urban Development funds the Section 8 voucher program that helps low income individuals pay rent on market-rate rental units. Criminal history may disqualify individuals from this program (Section 8 Voucher Program FAQ, 2010). The problem of having access to this type of affordable housing has been magnified because as the rates of SPMI adults in need of services has increased, there has been a decline in the number of affordable housing units (O'Hara, 2007).

The process of obtaining public housing requires a lengthy application process and spending time on a waiting list. Due to the high demand for public housing many public housing offices have shut down or frozen their lists making it difficult or impossible for new applicants to apply (Newman and Goldman, 2008). With so many people applying for a limited number of

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resources agency representatives, such as case managers, are often faced with the challenging task of determining what clients would be appropriate for independent housing. Criteria such as medication compliance, a lack of violent behavior, and sobriety are generally involved in this determination but this concept of “worthiness” may also involve a willingness to work with providers. Making a decision about worthy applicants often involves face-to-face meetings and potential applicants are often labeled, for some in a negative manner, which in turn may justify the case for being denied entrance to housing. What may be seen by providers as motivational, i.e. you may be able to access housing when you have meet these criteria, may have the opposite effect and that it can lead potential clients to reject treatment options and use substances to cope with rejection (Schneider, 2013).

### **Barriers to Maintaining Independent Housing**

There is no clear formula for preventing homelessness among SPMI adults once they have found housing. Although establishing housing is often the first step it does not encompass all that this population needs. Having supportive services in place is associated with higher rates of success in maintaining housing. Acceptance of having a mental illness is a key factor in working with providers. SPMI adults who lack insight into their illness are less likely to stay involved with treatment and continue taking prescribed medication (Schutt & Goldfinger, 2011). Strategies such as peer support and home based services may help to engage those adults who may have experienced a lack of involvement in the past (Montgomery et al, 2013). Further evidence of how SPMI adults benefit from living near peers with similar diagnosis will be addressed in more detail (Harkness et al., 2004).

### **Benefits of Independent Housing**

Independent housing is the option preferred by the majority of SPMI adults when given a choice (O'Hara, 2007). Research also indicates that having housing is a better predictor of someone avoiding hospitalization than having mental health services and that treatment efforts are at a high risk of failure when the person involved lacks safe and affordable housing (Browne & Hemsley, 2010). These factors point to the necessity and cost effectiveness of independent housing aimed at the estimated 4.6 million adults with SPMI who live the majority of their lives in a community based setting (Harkness, Newman, & Salkever, 2004).

Stability with mental health symptoms is related not only to having housing but having housing that creates a beneficial environment. Being able to maintain stable housing is cost effective when compared to emergency services used by homeless adults with SPMI or frequent psychiatric hospitalizations. What are some specific features related to a stable housing environment? Newer and properly maintained buildings have been associated with lower mental health care costs. In contrast buildings in need of repair were associated with a higher rate of resident instability. Having a greater number of services in or very near the housing was also a factor related to reduced costs of care. These amenities may include easy access to transportation, common meeting rooms, staff accessibility, and available green space (Harknes, et al, 2004).

Social support is another factor that has been linked to lower levels of stress experienced by adults dealing with SPMI. Those adults who lack social support are more likely to have suicidal thoughts and were more likely to have increased distress as a result of difficult events in life. Social isolation is often associated with severe persistent mental illness and this isolation often increases with homelessness. Having social support can help adults with SPMI cope with stress and deal with loss (Schutt & Goldfinger, 2011). Living in an independent setting where

other neighbors also have SPMI is associated with greater stability in maintain housing. Adults with serious and persistent mental illness may have an easier time forming social connections with people who have a similar diagnosis and have faced similar adversities in life (Harkness et al, 2004).

### **Assistance in Preventing Homelessness**

Research has led to increased understanding of the link between homelessness and mental illness and this has helped to develop evidence-based practices to address these issues.

Adjusting how services are delivered to this population has led to mixed results in reducing the number of homeless SPMI adults. Primary prevention methods include macro level interventions such as policies that reduce poverty, increasing the income of households and creating national entitlement to affordable housing. These efforts to change policies have not yet been implemented with the exception of the Supreme Court Case of *Olmstead v L.C.*. This decision requires states to provide community based living alternatives to institutionalized care for people with disabilities. A range of housing options is ideal because this allows people to live a setting that combines services with their level of need (Montgomery et al, 2013).

Intervention to prevent homelessness also takes the form of secondary prevention which includes programs that are in place to quickly identify and end an incident of homelessness. This may be addressed by helping to resolve a specific crisis that caused the loss of housing with the goal of returning people to former housing if and when possible. Secondary prevention may also take the form of housing subsidies, emergency rent, utility assistance or negotiation with a tenant and landlord. Prevention services that are considered tertiary (or the third level of intervention) are in place to improve housing stability. This area would address the needs of SPMI adults that



need more intensive services and may include options such as relocation, rental assistance, service engagement, and forming partnerships with landlords who may be willing to rent to tenants with poor rental history (Montgomery et al, 2013).

### **Housing First and ACT**

For many adults with a SPMI who have a co-occurring substance abuse disorder, achieving sobriety before they have a place to live is an unrealistic expectation. This population is more likely to be experiencing chronic homelessness and to have been involved with different forms of support without success. In the past these individuals have been required to finish treatment before receiving help with stable housing because the common belief was that a person who cannot maintain sobriety cannot handle living independently (Thompson, 2012). Research indicates that chronically homeless individuals have a high level of difficulty engaging in the treatment process without having housing in place. The Housing First approach does not require that a client meets the demands enforced by more traditional forms of intervention which generally include sobriety and a commitment to participate in treatment (Pearson, Montgomery, & Locke, 2009).

The Housing First Approach defines chronic homelessness as being a solitary adult with a disabling condition who has been homeless for at least one year continuously or experienced four or more episodes of being homeless during the past three years (Pearson et al, 2009). Research indicates that people with a SPMI make up a large percentage of the chronically homeless population (O'Hara, 2007). The first step in addressing the needs of this population is in finding suitable housing. This does not provide a cure to mental illness but does provide an environment where this can be addressed. Housing First also involves increasing the access to

housing for SPMI adults. Accomplishing this goal involves assisting clients in navigating the public housing system and also negotiating with landlords to secure opportunities. Although adhering to treatment is not a prerequisite of this program, providing treatment options and other supportive services are a large part of helping adults with SPMI maintain independent housing (Newman & Goldman, 2008).

The Housing First approach has demonstrated efficiency with reduced costs in shelter and service costs which include health care, hospitalizations, emergency room visits, incarcerations, and detoxification, but this approach does have some limitations (Thompson, 2012). Providing housing does not necessarily eliminate other factors that may interfere with success in maintaining housing. Strict rules prohibiting drug and alcohol use may lead to a higher rate of clients being discharged from a specific setting. Despite having these requirements homeless adults with SPMI generally accept offers for housing and are satisfied once they move in. Having an enforced set of rules has also been associated with higher satisfaction in regard to quality and safety of housing (Pearson et al, 2009).

Despite the availability of supportive services the decision to activate these resources is ultimately in the hands of the client. There is no single approach to housing and mental illness that can meet the varied needs of the SPMI population but engaging with supportive services while a person still has housing can help to develop a solid relationship. Engagement can happen with a variety of outlets at the community level (Montgomery et al, 2013). Community volunteers and peer based support groups may serve as social support channels for hard-to-engage clients. Other services such as drop-in centers allow the client to participate on their own schedule. It is important to remember that clients with SPMI who have a pattern of chronic

homelessness often experience a process of reintegration where they become integrated into the community one small step at a time (Schutt & Goldfinger, 2011).

The Housing First Approach underlines the benefits of providing housing before addressing other needs such as mental health and substance abuse. This approach does not suggest that ignoring these areas will lead to successful maintenance of long term housing (Pearson et al, 2009). The Housing First approach is often combined with other forms of intervention such as Assertive Community Treatment (ACT). ACT differs from traditional case management in that it incorporates a multidisciplinary team, small client to staff caseloads that involve more frequent contact, and community based services (such as day treatment and drop-in centers) that are a part of the ACT team. Assertive Community Treatment has demonstrated effectiveness in significantly reducing the length and frequency of hospitalization as well as increasing independent living for clients (Coldwell & Bender, 2007).

Although ACT has proven successful in treating clients with SPMI, using this intervention to assist adults from this population who are dealing with homelessness is a relatively new tactic (Coldwell & Bender, 2007). Traditional approaches to mental health service have generally required that clients see providers in an office-based setting. These traditional approaches to service delivery do not provide the flexibility and mobility that is necessary to support adults with SPMI who are homeless or have a history of homelessness (O'Hara, 2007). The homeless SPMI population is difficult to engage and Assertive Community Treatment is based on meeting clients on their own terms. ACT teams are available 24 hours a day for crisis response and work to provide continuity of care. When it has been implemented ACT has reduced the need for in-patient crisis services because the programming

helps clients to access community based services (Lehman, Dixon, Hoch, Deforge, Kenman, & Frank, 1999).

Assertive Community Treatment integrates services that would otherwise be accessible through numerous providers. These services include mental health and medical care, income support and housing assistance as well as substance abuse treatment and vocational rehabilitation. These providers generally work as a team which helps to improve communication and coordination. This type of service delivery is directly related to improved access to housing services (Rosenheck et al, 1998). Providing a large range of services with this type of improved coordination has also resulted in more days of stable housing for clients and lower costs related to in-patient and emergency room costs although this may include higher costs of outpatient service. Overall ACT has demonstrated more effective outcomes with costs that are no more expensive than more traditional services (Lehman, et al 2013).

In conclusion adults with SPMI face an uphill battle in both finding and maintaining independent housing. These difficulties can be increased by actively engaging in substance abuse and by the symptoms of mental illness that may inhibit the ability of the adult to interact with peers and leave them lacking in social support in times of need (Schutt & Goldfinger, 2011). Not having the ability to engage socially can also create difficulty in working with providers and those individuals who lack this ability may be judged inappropriate for independent housing (Schneider, 2013). This type of housing does provide a cost effective solution for homeless adults when compared to the costs of frequent hospitalization (Harknes, et al, 2004). One of the challenges that providers face is in engaging these individuals who may have lived on the fringes of society (Rothbard et al, 2004). Assertive Community Treatment has given providers more flexibility in meeting adults with SPMI on their own terms (Coldewell &

Bender, 2007). The Housing First approach has also been beneficial in part because having housing is an important aspect of treatment compliance. Thus a person is more likely to take prescribed medications and maintain sobriety when they have the asset of permanent housing (Newman & Goldman, 2008).

### **Conceptual Framework**

This study focused on evidence based policy and the Housing First approach and was conducted as qualitative research. There are multiple barriers to maintaining independent housing that are faced by adults with SPMI and this has led many to the belief that there is not one single approach to assisting this population. The interactions between clients and providers are constantly changing and thus a further examination of the mutual reality shared by these two parties is necessary to better understand factors such as motivation for change and the process of engagement (Grinell & Unrau, 2011).

A qualitative research study is further beneficial to this topic because the individual voices of both providers and clients are invaluable. Existing research identifies that factors such as living near peers with an SPMI is related to less frequent hospitalization and increased ability to maintain housing for mentally ill adults. This is an important concept in assisting this population but what is not easy to understand from quantitative research is how the process looks. Are there certain factors that promote engagement between clients in an independent housing setting that help establish rapport and in turn improve socialization skills?

Evidence based policy initiatives are those that are supported by research evidence. These policies are introduced on a trial basis and are evaluated thoroughly. The purpose of this type of policy is to create a higher level of accountability and to identify areas of improvement.

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It is the underlying philosophy of evidence based practice that applying the scientific process and research to social problems will result in sustainable solutions. Research findings are presented as being reliable and objective because they are based on measured outcomes that produce generalizable results which in turn can help to predict future outcomes. Deciding what works in evidence based practice is further decided by cost-benefit and system analysis (Stanhope & Dunn, 2011).

There has been a wide range of research focused on the homeless population with SPMI I relation to the deinstitutionalization and this research has continued as a reaction to the increase in urban homelessness in the 1980's. Research focused on the population of homeless adults with SPMI estimates that in Minneapolis, an individual from this population can use over \$110,000 per year with combined costs of incarceration, shelter services, emergency room visits and acute hospitalization services. Based on these findings an evidence based approach was developed to address the needs and preferences of homeless mentally ill adults. This attempt to assist clients from this population who had been previously hard to engage is referred to as the Housing First approach (Stanhope & Dunn, 2011).

The basis for the Housing First approach can be found in the Pathways to Housing program which was founded in New York City in 1992. This mission of this program was to engage the homeless population that had previously been hardest to reach by providing immediate access to housing. This access was not dependent on clients maintaining sobriety or participating in mental health treatment services. Participants were, however, given access to a variety of services and this model was based in part on the wrap around services that are part of Assertive Community Treatment. The concept was considered revolutionary because traditional approaches required that participants were engaged in some form of treatment before housing

was provided. Pathways to Housing incorporated the concept of harm reduction which requires that providers meet clients where they are at in terms of willingness to change substance abuse patterns. In some cases where a client does not want to become sober the provider may help them to minimize the negative consequences of substance use (Stanhope & Dunn, 2011).

As evidence based practice has continued to evaluate the Housing First approach it has shown that having housing greatly improves the ability of clients to engage in treatment. When compared with other housing models that have demands such as sobriety, the Housing First approach has demonstrated a higher level of housing stability (Pearson et al, 2009). This study focused on barriers to housing and models of intervention such as Housing First and how elements of client engagement can assist in long term maintenance of independent housing.

### **Methodology**

#### **Research Design**

This research design involved qualitative data. As referenced in the literature review, adults with SPMI are at a much higher risk for becoming homeless and remaining homeless for longer periods of time than those without SPMI. What is not clear from this research is how the intervention process between providers and clients breaks down barriers to maintaining independent housing as well as how approaches such as Housing First and ACT affect the process of client engagement. This research provides the rationale for researchers to identify where gaps in service may exist in examples of discharge planning and ongoing support services and also where specific services and interventions have been found effective. This study was exploratory due to a lack of present information on this subject. In order to measure effective service delivery, a variety of providers including ACT team members, IRTS facility supervisors,

hospital social work staff, and other homeless outreach providers in the Twin Cities are were interviewed to identify personal experiences and professional views of what may better serve this population

The sample for this study was composed of eight service providers in the Twin Cities area. These providers each work in some capacity with adults dealing with SPMI and have experience ranging from ACT Homeless Team members, IRTS (Intensive Rehabilitative Treatment Service) facility counselors, hospital social workers, and other community support providers. It is my belief that this variety offered an introspective and interdisciplinary look into this subject. These providers were selected based on theoretical sampling to give a broad perspective on this subject. This involved sampling across stakeholders and perspectives to better understand the phenomenon of supporting successful housing for adults with SPMI.

This sample was interviewed either by phone (5 participants) or in person (3 participants). Interviews took place in a location chosen by each individual participant. An option was presented by the researcher to use a private conference room at the researcher's workplace as well as options to use private conference rooms at local public libraries. The participants were also informed in advance that interviews will be audio recorded and saved in a laptop computer file. This was a purposive sample with some participants being identified by a snowball method. The researcher first asked committee members for input and then went through a list of potential participants with the committee chair. This type of sampling was chosen in part because of contact this researcher has had with professionals in this field combined with a desire to better communicate and understand resources available to the SPMI population. The people I interviewed were not people with whom I have a close personal or working relationship. Participants were asked a series of questions designed to initiate feedback



about characteristics and personal experiences working with SPMI adults in relation to better supporting independent housing.

### **Protection of Human Participants**

Protection of the sample participants was maintained during and after data collection and while this data is analyzed and disseminated. Interviews were digitally recorded and then transcribed by myself as the researcher. These digital interviews will be deleted from my laptop computer in May 2014. Informed consent forms were given to participants at the beginning of the meeting and I explained this area before the interview begins. These consent forms were created using a template from the University of St. Thomas and explained the research question, procedures for the interview, confidentiality, and the voluntary nature of participation. These forms were reviewed and approved by the committee chair. Each research participant was interviewed with the same set of questions and received a copy of these questions two weeks prior to the scheduled interview.

This research coordinator de-identified the data by removing the names of participants from the transcribed interviews. While transcribing interviews I removed any potentially identifying data. Paper transcripts were kept in a locked storage cabinet in my home. This researcher accessed the data only for the purposes of analysis and interpretation of project findings. Data that specifically uses the names of participants and audio files will be deleted after completion of the clinical research project in May 2014.

As another measure to ensure the protection of participants, a proposal was submitted to the University of Saint Thomas (UST) Institutional Review Board (IRB). The researcher made

any necessary corrections that are required by the IRB to complete this research project within the allotted time frame.

### **Data Collection**

Interviews for this project took place in person between the researcher and individual participants. This will use a semi-structured question format with ten prepared questions which elaboration is encouraged. Participants were presented with questions about resource availability, the process of client engagement, the advantage of having choices in housing, and experience/ feelings about the Housing First approach. Participants were also asked to identify gaps in existing services, aspects of the engagement process, and suggestions for improved coordination of services. Specific questions focused on aspects of working with clients with a history of substance abuse and how housing stability plays a role in adherence to treatment.

### **Data Analysis**

This study used both deductive and inductive approaches. The basis for the interview questions was drawn from the research literature. This research indicated that success rates for mental health and chemical dependency treatment were increased when the client being served has stable housing. Research has also shown that mental illness and substance abuse are not necessarily the cause of homelessness but are contributing factors and that the rate of mental illness and substance abuse disorders are much greater among the homeless population than of the general public.

Information gathered from interviews has the potential to provide a better understanding of specifically how these contributing factors can lead to homelessness and what may be necessary skills and services to overcome these barriers to maintaining independent housing. To

find common themes, the interviews that were conducted as part of this study were transcribed and reviewed by this researcher to identify codes that are present within the data. These data were then organized into common themes and further divided into sub-themes.

The validity of this research is dependent in part on the diversity and responsiveness of participants. Having a range of participants from different areas of expertise was highly beneficial to this process as well as their willingness to speak freely about gaps in service delivery without fear of judgment. It was hoped that these different participants would converge in some areas of knowledge but also offer unique responses and perspectives on this subject.

### **Strengths and Limitations**

The primary strength of this study is the direct insight from providers who are working in the field in providing assistance to SPMI adults. The questions that were used for interviews are based on research findings and the information gained from these interviews could potentially be useful in future research. The interview participants are stakeholders in reducing and eliminating homelessness specifically among the SPMI population and therefore have some motivation to improve the delivery of service. The one on one interview format also presented an environment where participants are ideally not afraid to point out shortcomings in areas of programming that they have observed.

Despite having these strengths this proposed method of study does have some potential limitations. The participants are all based in the Twin Cities metro area and their experience may be unique to this area and not generalizable in all aspects to the SPMI population across the country. Finally another limitation could be the cultural diversity of the participants. Diversity

among participants may be a factor that adds to the range of viewpoints and may also affect the range of responses about preferred methods of intention in regards to assisting clients in maintaining independent housing.

## **Results**

This study was comprised of eight service providers in the field of housing and mental illness in the St. Paul/ Minneapolis metro area. The respondents were primarily Caucasian in racial background and varied in age between approximately 30 and 55. Three of these providers worked in IRTS facilities, two as mental health counselors and one as the clinical director. One provider worked as a peer support specialist (also with an IRTS facility), and another worked as a hospital social worker in inpatient psychiatry. Two providers worked as case managers, while one of these was a case manager for an ACT team and another worked in a more traditional case management setting for a non-profit agency. That last provider was the president of a non-profit housing program.

Respondents answered a series of 10 questions that were broken down into three distinct themes including barriers that impede or discourage success in maintaining independent housing (barriers to housing), aspects that determine or foster success in maintaining housing (success factors), and intervention strategies that assist in the process of accessing and maintaining housing (intervention strategies).

### **Barriers to Housing**

Some of the aspects most frequently cited by respondents included a lack of rental history, a poor rental history (including any history of evictions or unlawful detainers) and/or a criminal history. The link between having a history of non-compliance with medication and not paying bills related to housing was also cited by respondents as was lacking sobriety and having

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a lengthy substance abuse history including multiple hospitalizations for either substance or mental health related issues. Lacking a support system was also listed and in the words of one provider, “I don’t know a lot of people I work with (as a mental health case manager) that are able to live without any type of support.”

A general lack of housing options was also seen as a difficult barrier in housing access. Service providers who worked with clients in or closely with IRTS (Intensive Residential Treatment Service) facilities expressed frustration over the time limitations placed on these types of programs (which is generally 90 days). The main objective of IRTS facilities is to treat and stabilize mental illness but finding stable housing after the completion of these programs is not a primary focus of insurance providers who fund these services.

According to those interviewed, aspects of the physical environment can also impede the ability of adults with an SPMI in maintaining independent housing. This might include living in an area where drugs are easily accessible. These conditions can trigger or influence someone who has a dual diagnosis (mental illness and substance abuse disorder) to use. A case manager who was interviewed pointed out that the current housing environment is in favor of the landlord, meaning that due to increased demand more people are applying for fewer available units and this leads to increased housing costs and a limited amount of options. Someone might recognize that where they live makes it difficult to maintain sobriety but may not have access to any other housing.

One respondent who, as a peer support specialist, lived in a large income based housing facility in the metro area discussed his experience: “It was a hopeless feeling when I was there and it had a tremendous effect on my self-esteem. Drug dealing was everywhere and the police were there constantly. There were a lot of elderly people living there who were low income and

it would happen all the time that someone died. I mean this is what you dealt with every day.”

Housing that is outside of the immediate metro area may limit access to drugs but may also limit access to service providers and transportation.

A history of substance abuse can lead to a number of difficulties in maintaining housing. A peer support specialist described that the effects of mental illness are magnified many fold when combined with substance abuse. Another respondent pointed out that this co-morbidity characterizes the population of chronically homeless. When someone is homeless, substance abuse patterns often increase which can in turn create difficulty when presenting to potential landlords. These patterns vary from person to person once stable housing has been acquired. For some people having their own housing may create new issues of isolation and using drugs or alcohol becomes a way to connect to others.

One IRTS provider described her observations regarding the pattern of substance abuse combined with mental illness in relation to independent housing: “It seems to create a perfect storm in that people use more when their symptoms of mental health are out of control and this causes their symptoms to become even more out of control which causes difficult in taking care of their residence and they can end up homeless. I have found that there are drugs everywhere but homeless shelters (in particular) can be hot spots for access to drugs. This makes sense because it is probably a good market for finding people who want to use because they are having a hard time.” Respondents who addressed the issue which treatment methods were the most effective felt that dual recovery programs for treating the co-occurring disorders of mental illness and substance abuse were the most beneficial to clients. A hospital social worker added that it was much easier to access chemical dependency treatment than dual recovery treatment.

## **Success Factors**

Among the eight respondents to this survey there were a number of factors discussed that when present in a housing situation can foster success. Survey question number five asked about social support and respondents agreed that this is an important aspect for adults with an SPMI to maintain housing. One respondent worked as a peer support specialist and had first hand experience maintaining housing while dealing with mental illness. He reported that living in a situation that promoted socialization that had some level of choice combined with some requirement that people living there participated on at least some minimal level was the most beneficial option. This professional pointed out that many residents may not recognize the need or benefit of socialization but that they would get involved if it was identified as a necessary aspect of the housing program.

### **Promoting Socialization**

A hospital social worker added that these types of programs that promote socialization result in residents staying for substantially longer periods of time. To promote socialization it is also necessary to have common areas where this socialization can take place like such as meeting rooms. Some facilities have tenant groups that plan activities such as bingo and help residents gain a sense of connection and community.

### **Access to Public Transportation**

Another factor that was indicated by the majority of survey participants was the location of the housing especially in terms of having access to public transportation. When residents had easy access to public transportation this helped them to access resources in the community especially in getting to psychiatric and medical appointments. Access to transportation also affects the ability to socialize and stay connected with family and friends. One case manager

indicated that adults dealing with an SPMI may be much more open to suggestions and observations made by family and friends such as a need to meet with a psychiatric provider.

### On-site Support

Having on-site support is another important factor in maintaining housing for adults with an SPMI. Some programs may have professional staff that can go as far as assisting residents in dealing with neighbor conflicts but just having an apartment manager who is respectful and available can go a long way in improving residents' self-esteem. One case manager pointed out that "residents tend to become frustrated when they are living in a larger facility with more apartments per building and that the only access they have to management or maintenance staff is by leaving a phone message.

### Drop-in Centers

Finally drop-in centers were also mentioned as an important resource to assist adults with an SPMI in maintaining housing. One IRTS facility staff member discussed a program he had worked with in the past. "If a facility offers free laundry services or meals it is a big motivator and people slowly became part of a social network. People would often contact this drop-in center after moving away years earlier because they knew they had a connection. Some times when drop-in centers have too many rules have for participation than it makes it difficult to reach consumers. It really needs to be a supportive and non-judgmental environment."

### Crisis Beds

Providers working in both an IRTS facility and in a hospital setting discussed the benefit of having crisis bed availability and how this was beneficial to adults dealing with SPMI. "Having a crisis bed situation where someone can come in for help and (know) their housing will be there when they get through the crisis is a huge factor in helping them maintain their



housing.” This provider cited funding issues as being linked to the lack of current availability. In the past when this service was funded through the county it was more accessible because it is problematic in billing insurance for crisis bed services. If providers can work to lower the fear involved with utilizing crisis beds or inpatient psychiatric services, then clients are more likely to seek help before their mental health symptoms become unmanageable.

### **Intervention Strategies**

Different questions asked in these interviews focused on methods and intervention strategies that providers found useful in providing service to the SPMI population dealing with housing issues. Providing consumer choice in housing options was unanimously described as an important part of enhancing client motivation. A hospital social worker discussed how, because she works with clients on more of a short-term basis, that she often has difficult conversations with clients about limited housing options which may be dictated by a person’s history. Even when doors may appear closed in terms of housing options, providers may be able to advocate for clients and get them on housing lists even though they may have been initially denied. Certain characteristics of the physical environment can contribute to the ability to maintain housing.

Some of the providers interviewed discussed the benefit of getting to know landlords and how advocating for clients in these types of situations may prevent a client from housing loss in some cases. The role of Assertive Community Treatment (ACT) teams was seen as a valuable tool for providing assistance because of the frequency that providers meet with clients and the convenience of having multiple providers under the same roof. This approach allows providers the opportunity to get to know clients more quickly which in turn can lead to forming trust and

engagement. This is not to imply that traditional forms of case management are inferior to those services provided by ACT but most providers felt that this approach puts providers in a position to identify needs and address them more promptly.

Client engagement and establishing rapport was identified by participants as being important when assisting adults with an SPMI in finding and maintaining. This is done by understanding the client's goals and trying to meet them where they are at in terms of sobriety and mental health management. One case manager elaborated on the process of working with individuals who are dealing with homelessness: "I try to show up to each meeting with housing leads that I have put together which are related to options they are interested in. This gives them motivation and incentive to meet." An IRTS provider addressed the need for non-judgmental attitude and that when a client understands this they are more open and honest in terms of drug or alcohol use. "Their attitude (the client's) is much different than a system where you are trying to catch someone doing something wrong like in using UA's (urine analysis/drug testing)."

Client engagement was closely related to consumer choice in housing. Most interviewees pointed out the difficulty in not seeing eye-to-eye with clients on the most appropriate placements. A hospital social worker discussed the process of client motivation: "You might get people who have been in the system for 20 years and their choice at this time is I don't care. There are also times when a client's history dictates where they may be offered housing and those can be difficult conversations to have." Most providers agreed that, in most cases, clients usually want the most independent option which tends to be their own apartment. One IRTS provider felt that getting this stable housing in place (or at least knowing that it is secured for the future) is a big part of the recovery process. "I have seen many times where having housing can really help people achieve mental health stability and sometimes it's tough because a housing

program may want to see a person become stable, then get a job, and then get an apartment. I think that is true for any of us. I know that personally my job and my housing are a big part of my mental health stability.”

The majority of these survey participants served to varying degrees as client advocates and they offered insight into how this process works. First of all it is important to be upfront about client history when working with other providers even if this may end up closing the doors to certain opportunities. Sometimes the role of an advocate may be able to change the perception of a housing provider in aspects such as explaining criminal history. One hospital social worker described her approach as “politely persistent” and that continuing to offer updates on client progress might be the information a facility needs to hear to change their initial decision on offering housing.

Providers in this sample used the Housing First Approach to varying degrees in their practice. This can be more difficult with certain clients, who, because of past history may have a difficult time accessing independent housing options. Discussing long term vs. short term goals may help a client to understand that certain steps are necessary to achieve that ultimate goal, which may be their own apartment. One ACT case manager discussed his agency’s approach as dealing with the needs presented on that particular day. “If someone wants to work on housing and you suggest taking a look at mental health symptoms than you are likely to be met with resistance.” IRTS facility providers felt that incorporating a Housing First approach was necessary because for a resident to function in a time limited program they need to have some security that they are going to have a place to live following their discharge.

### **Primary, Secondary, and Tertiary Intervention Strategies**

Providers in this survey were asked about different primary or macro level interventions that could assist this population. Many providers admitted that for the most part, that they did not spend a significant amount of their time with this level of service. One exception was a contracted case manager who worked for a non-profit agency. “Our facility is pretty active with legislation and we participate in Mental Health Day at the State Capital and bring clients who want to attend and set up appointments to me with representatives. As a non-profit agency we do not want to sway people one way or another but we encourage people to get involved whether it is city council or public planning meetings.”

Secondary level interventions were described as strategies and resources that can quickly assist someone who has recently become homeless. These strategies were listed more frequently by providers with the most common response being short term crisis centers and shelters as well as shelters that provided service to victims of domestic violence. One provider working as a peer recovery specialist did cite that shelters were a very beneficial but at the same time he felt that when someone has a secure place at a shelter they become less motivated and less likely to search for housing. Another provider working as an ACT case manager described a rapid re-entry program that was part of a non-profit agency. Clients must meet certain qualifications to receive this service but when they did it was very beneficial in helping them to access independent housing.

Finally tertiary strategies were those that could improve housing stability. An IRTS provider described the process of assisting clients during the treatment process with role-play activities that could help them deal with situations that may arise in the community such as dealing with a neighbor or landlord issue. Services such as ARMHS and ILS (Independent

Living Skills) were listed by numerous providers and seemed to be the most popular response. One case manager cited that advocating for clients and meeting with landlords often resulted in more favorable decisions on housing status. Coaching clients to advocate for themselves was also listed as being helpful in maintaining housing.

In conclusion these varied responses offered an in-depth perspective on the different aspects of providing service to adults dealing with a severe and persistent mental illness. Having a diverse background of professionals was important because no single approach will work for every client. This population is disparate in terms of mental health diagnosis, level of social support, history and current level of substance use, and history of incarceration as well as many other aspects. Universal themes seemed to be: the necessity to engage the client and trying different methods, being prepared with resources, having a non-judgmental attitude, and meeting the client where they are at in terms of recovery help to build this foundation.

### **Discussion**

This research explored the barriers to housing that adults with a severe persistent mental illness face in maintaining independent housing and strategies used to both engage and to help these adults. In contrast to existing data, this study compared a relatively small sample size of practitioners who provide service to this population and serve the Minneapolis/St. Paul area. This discussion highlights the findings of this study while addressing strengths and limitations, implications for future research, training suggestions for social workers providing assistance to this population, and further practice implications.

In conducting this research three distinct themes emerged which included barriers to housing, success factors, and intervention strategies. Intervention strategies and success factors will be addressed further in the practice implications section where the combined experience of

providers is evaluated to identify methods of service delivery. When identifying barriers to housing, the responses of the participants strongly reflected the literature in citing a lack of housing options as being the most significant barrier. Respondents discussed the difficulty in assisting clients when there is a lack of resources. The lack of housing is magnified when combined with time limits in programs that may be transitional like IRTS facilities which currently allow residents to stay for a maximum of 90 days. It is more difficult to motivate and engage clients in the process of finding housing when these options are limited and there is no choice in the matter.

A lack of available housing was seen as the most difficult barrier to overcome. Having a criminal record and/or a poor rental history combined with an SPMI means that if an adult loses their housing they will face a difficult challenge in accessing other housing. Although this survey did not address specific numbers, most respondents felt that housing options that are available to this population have decreased which leads to more people applying for fewer available housing units. One provider described this is a “seller’s market” and landlords are more selective about who gains admittance.

Understanding this shortage means that there is an even greater importance on maintaining housing. Having different outlets for social support can assist SPMI adults in this process. SPMI adults who have a history of homelessness may have burned bridges with friends or family members or, because of symptoms such as depression and paranoia may have a difficult time connecting with peers. Resources such as drop-in-centers provide a safe environment where consumers can meet people who have common interests and shared life experience.

## **Housing First**

Survey participants reported using the Housing First approach to varying degrees. Hospital social workers interviewed reported focusing on establishing some form of safe housing when a client is discharged. The length of time clients are hospitalized is often relatively short, so this provides limitations in the ability of the hospital social worker to search for housing options vigorously with each client and fully incorporate this method. IRTS facility staff were generally familiar with and were incorporating the Housing First approach with clients. One IRTS provider described a program he felt was very similar to this approach. He felt the most important aspect of this program was the involvement of staff and going on-site to meet with landlords and clients to solve problems. This program would also provide resources such as sending their own maintenance crews out to fix damage that was caused by clients in an effort to help them maintain their current housing.

Another provider described how the IRTS model itself worked well and was beneficial because it met, at least temporarily, the need for housing that is presented by most clients. Through IRTS residents have a place to stay for a set amount of time and they also have assistance in finding long-term housing. According to another survey participant, the most common goal of clients while they are in an IRTS facility was to find housing so providing assistance with this goal also helps with engagement.

IRTS facilities vary in terms of the actual facility with their ability to model a Housing First Approach based on their rules toward sobriety maintenance. Traditionally IRTS facilities differed from this approach in that they required facilities that participants maintain sobriety. A newer approach incorporated by IRTS facilities involves using lapses in sobriety as teaching

moments. Facilities may also differ in how strictly policies relating to sobriety are enforced in giving clients multiple chances if they are also demonstrating an engagement in the treatment process. In some cases repeated incidents of substance abuse would result in discharge from the program which would potentially leave the client in a situation of becoming homeless. These facilities also differ from the Housing First approach in the environment itself may serve to restrict drug or alcohol use. Resident are generally allowed unsupervised time in the community but they are also required to spend a certain amount of time at the facility which would not allow on-site chemical use. The Housing First approach provides treatment options but does not require that clients being served participate in mental health treatment or that they maintain sobriety while receiving service. This approach would also be in contrast to the services provided by traditional IRTS facilities in terms of mental health treatment. While Housing First provides resources for mental health based treatment, the goal of IRTS facilities is to provide treatment and someone who refused to participate in this aspect may either be denied admittance or discharged from the program (Schutt & Goldfinger, 2011).

In this survey, two case managers were interviewed, one working with an Assertive Community Treatment (ACT) team and one working for a non-profit agency that contracted service through a metro county. The ACT case manager discussed his agency's philosophy of working with what is presented on that given day. This may be housing needs but it does not mean that addressing mental health or substance abuse gets ignored. This provider did express that if someone does not have stable housing than this is often the need they are presenting. The contracted case manager was not as familiar with the Housing First Approach and pointed out examples from her practice where she has observed reducing or abstaining from substance use once they had housing.



Finally the remaining provider worked as a peer recovery specialist with an IRTS facility and as the president of a non-profit housing program. The peer recovery specialist was not familiar with the Housing First Approach but ,when it was briefly explained, expressed his view that recovery was a basic part of maintaining housing and that someone who is dealing with these recovery issues could be very disruptive to a housing program. In contrast the provider who worked with a non-profit housing program reported that the Housing First approach was embedded in their delivery of service. This program does not require that clients are sober as a stipulation for entry. It was the provider's belief that this strategy makes it easier to work with clients because it helps engage clients and meet them where they are at.

In evaluating these responses it makes sense that Assertive Community Treatment would support the Housing First approach in that both of these are evidence based practices. From the brief description given by this provider it did not appear that anything reported was in contrast with the Housing First approach. In regard to the contracted case manager there may have been some misunderstanding in the initial question in that she did not actually describe Housing First so it is unclear of how much if at all this approach is incorporated into service delivery.

The role of a peer recovery specialist is based on their personal experience in dealing with mental illness. This professional did not believe that the Housing First approach would have been beneficial to his recovery process but someone else who had benefitted from this approach may have a very different view on the subject. It is not an expectation that someone working as a peer support specialist have an extensive education and experience in other forms of intervention because their primary strength is in assisting others is in their knowledge of the specific treatment that was beneficial to them.

The non-profit housing program described by this provider incorporated the Housing First approach into its practice. This provider addressed that lack of income and not maintaining lease compliance were the biggest barriers to finding and maintaining housing. She cited that this specific program was not based on addressing substance abuse or mental health needs but that outreach workers did help clients to connect with these resources. Potential residents would also be responsible for applying and accessing this type of resource which would likely mean that this facility would be working with other providers and not solely responsible for adhering to the Housing First approach.

### **Strengths and Limitations**

This study provided valuable information from a diverse range of providers serving the Minnesota metro area. This information can be used to inform and benefit practitioners not only in the field of social work but also in areas such as healthcare and housing. In contrast to previous studies, this research helps to pinpoint what barriers providers have encountered when serving clients in a specific geographic area and offers insight into different approaches to assisting this population. Furthermore this study helps put a face to those people who are affected by the lack of low-income independent housing who appear often to be individuals with a poor rental history or a history of criminal convictions.

One interesting aspect of this study that may be a limitation is the lack of an agreement by all providers on a common definition for what independent housing entails. Even with a clear definition for what constitutes as independent housing in an interview format such as this it is understandable that providers had different opinions, depending on their practice context. Many of the IRTS providers tended to feel that a situation that was more independent and/or less

restrictive than this type of facility was more independent and thus fit their definition. This may include facilities like a board-and-lodge in which residents live in a larger group setting with minimal staff supervision. Other providers talked about shelter options because this is the most easily accessible option for someone who is experiencing homelessness. The background research for this project generally cited that options that presented the least restrictive environments were related to higher resident satisfaction (Schutt and Goldfinger, 2011). These options created the most cost-effective options when compared to the costs of frequent hospitalizations or incarceration (O'Hara, 2011). It is unclear if some of these options suggested by providers would rank as highly in resident satisfaction and these facilities may offer both assistance and restrictions, but they may very well be cost effective in terms of reducing the number of psychiatric hospitalizations for residents.

### **Practice Implications**

The combined experience of the providers who participated in this research brought forth a number of methods that would be beneficial in providing service to adults with a SPMI with the goal of obtaining and maintaining independent housing. These are addressed in a format that coincides with the establishment and development of the client relationship:

#### Engagement

This process starts when first meeting the client and getting to know what is important to them. It is not the start of a productive relationship when a practitioner is more focused on goals they think are necessary versus goals that the client feels are vitally important. This involves meeting the client where they are at in terms of sobriety, housing, and mental health treatment. If someone is homeless, living in an unstable housing situation, or is highly dissatisfied with their

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current housing, this area is likely to be their primary goal. Clients like to see a provider who has done their homework and is prepared and this might mean having new housing options and bringing them to each meeting.

### Barriers to Housing Access

Having a poor credit or criminal history can severely impede access to housing. In a housing market where resources are scarce and having these barriers in place can make the search nearly impossible. Advocating for clients may be able to open doors that appear to be closed and considering a “politely persistent” attitude could be beneficial. “Your housing program disqualifies applicants with a felony but I am wondering if you would consider a client I am working with who has a felony charge x amount of years ago but who has worked hard to turn his/her life around and has had no charges since this time.” Having a client’s permission to release information and being honest in the exchange with housing providers are also necessary to overcoming these barriers.

### Factors in the Housing Environment

Access to transportation (bus routes) was reported as important because the majority of clients being served rely on this to get to appointments and for social needs. Research has been linked to greater client satisfaction in smaller buildings that have common areas for socialization (Harkness et al, 2004). Providers also cited the benefit on having on-site management staff that residents can talk to if there is a problem. Finally, having recreational or social activities as part of the program can also assist SPMI adults in meeting peers and forming relationships.

### Maintaining Housing

Although finding housing in itself was seen as the biggest obstacle facing this population, different challenges arise once secure housing has been established. One of the most common themes expressed by providers in overcoming the barriers to maintaining independent housing was in developing a relationship with landlords. When providers have developed these relationships it has led to more understanding of mental health issues and a willingness to give second chances when a client may have violated certain rules. When residents have developed a relationship with their landlords they are more likely to advocate for themselves and express dissatisfaction before situations turn into a bigger problem.

### Socialization

Providers cited that many SPMI clients who have a history of homelessness may have burned bridges with friends and relatives and may also be untrusting of other making it difficult to form new social relationships. Drop-in centers were seen as a valuable resource because they allow adults with an SPMI to connect with peers who may be facing the same difficulties. These facilities were seen as the most beneficial when they did not have stringent requirements for participation and also when offered something beneficial to the clients, like laundry service or meals, in addition to the social aspect. Overall drop-in centers were viewed as good way to reduce loneliness and isolation.

### Housing First Approach

Although providers did not all use this approach in accordance with the housing first model, most agreed that having stable housing could greatly improve mental health stability and reduction of substance abuse and/or sobriety. Providers reported that when clients had some

level of desire to maintain their current housing they were motivated to work on these other aspects. The majority of providers also felt that accessing housing was the primary need expressed by clients and that failure to recognize this goal could damage the client relationship.

### **Suggestions for Future Research**

This research helped to better understand the issues adults dealing with a severe and persistent mental illness face in both securing and maintaining independent housing and how providers can provide beneficial service to this population. Future research might focus on a more in-depth look at how to help SPMI adults who have poor credit and a criminal history overcome these barriers and successfully obtain independent housing. These factors seemed to create added difficulty in the process and the general consensus of providers interviewed for this project was that a lack of housing options places this population at an even greater disadvantage.

Other areas for future study might include a focus on macro level interventions that are aimed at addressing issues surrounding the lack of housing options for adults with a severe and persistent mental illness. Past research indicates that cuts in affordable housing and a lack of mental health programs directed at homeless prevention will result in an increase in homelessness among the mentally ill population (O'Hara, 2007). The participants involved in this research had a diverse background but only one reported experience in helping clients advocate for policy change.

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Barriers to Maintaining Independent Housing Faced by Adults living with SPMI

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Adults with a severe and persistent mental illness who are also experiencing homelessness face a difficult challenge in both finding and maintaining independent housing. This level of difficulty is increased when dealing with added issues of substance abuse and a lack of social support. Affordable housing options have also not risen at a substantial rate to meet the needs of this population. The purpose of this project was to explore what factors and resources are important in helping adults from this population overcome barriers to access and maintain independent housing. Using a qualitative design eight professional staff who work closely with homeless and mentally ill adults were interviewed using a series of ten questions. Data were analyzed using a deductive approach and three distinct themes were identified including barriers to housing, success factors, and intervention strategies. The most common barriers to housing access cited by these professionals were a lack of available and affordable housing, a criminal record, and/or a poor rental history. Aspects that foster success in maintaining housing included developing a relationship with landlords, having housing that promotes socialization, access to public transportation, and access to drop-in centers. Finally, intervention strategies that assist in the process of maintaining housing cited by professionals in this survey involved engagement with clients, consumer choice in housing options, and meeting the client where they were at in terms of treatment and recovery. These findings stress the importance of acquiring and maintaining housing as critical pieces to achieving mental health stability.