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Prevalence of Mental Disorders Among People Who Are Homeless

Estimates of the prevalence of mental disorders among people who are homeless vary considerably, and much depends on methodological differences among studies, although there is no doubt that such disorders are significantly more common among people who are or have been homeless than among those who have always been domiciled (Greenberg & Rosenheck, 2010a) and are also more common among those who are chronically unsheltered compared with those living in shelters (Levitt, Culhane, DeGenova, O'Quinn, & Bainbridge, 2009).

Other quality data come from large national studies that included people who were formerly homeless. In analyses of data from both the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) and the National Comorbidity Study Replication (NCS-R), Greenberg and Rosenheck (2010a, b) found that people who had experienced homelessness in adulthood were significantly more likely to have every mental disorder included in those studies, with the exception of panic disorder with agoraphobia in NCS-R and agoraphobia without panic disorder in NESARC.

An earlier literature review on physical and mental disorders among those who are homeless (Martens, 2001) cited reports that found that anywhere between 25 and 90 percent of people who were homeless had a mental disorder. A review by Toro (2007) suggests that 20 to 40 percent of people who are homeless have a serious mental disorder, with 20 to 25 percent having depression and 5 to 15 percent having schizophrenia. In their introductory review, Greenberg and Rosenheck (2010a) note that estimates are that between 20 and 50 percent of people who are homeless have serious mental illness (SMI). Research reviewed by McQuistion and Gillig (2006) also indicates that between one third and one half of people who are homeless have SMI.

Although it did not assess particular mental disorders, the 2010 Annual Homeless Assessment Report (HUD, 2011) did ask shelter staff to count the number of adult shelter users with SMI during its single-night count (the method used to determine SMI varies from State to State, but it generally relies on participant self-report). In that year, 26.2 percent of people who were homeless and using shelters were reported as having SMI. As the report notes, the percentage of people who are homeless with SMI is likely higher, as many of those individuals avoid the shelter system.

Fazel, Khosla, Doll, and Geddes (2008) sought to determine the prevalence of mental disorders in persons who were homeless in seven Western countries (including the United States) by using a metaregression analysis of 29 surveys conducted between 1996 and 2007. Based on studies that evaluated psychotic disorders (28 of the total), they estimated that 12.7 percent of individuals who were homeless had a psychotic illness, 11.4 percent had major depression (based on 19 studies), and 23.1 percent had a personality disorder (based on 14 studies). It should be cautioned, however, that differences in behavioral health services and housing found in European countries (also included in the review) may mean that rates in the United States could vary significantly from these estimates.

Other estimates come from smaller, local studies. For example, in a 2000 survey of 298 men and 98 women recruited from shelters and public places in the St. Louis, MO, area, North, Eyrich, Pollio, and Spitznagel (2004) found that 23.1 percent of men and 18.9 percent of women had

onset of homelessness and that rates of ASPD were not significantly affected when the ASPD symptoms thought to be confounded by homelessness were discounted (North, Smith, & Spitznagel, 1993).

An under-recognized problem among adults who are homeless may be attention-deficit/ hyperactivity disorder (ADHD), which has also been linked to elevated rates of substance use disorders among adults in some studies (Levin, Evans, & Kleber 1998; Faraone et al., 2007). Although there has not been much research on the subject, one study of 81 veterans

lifetime impulse control disorder with 1.63 times the risk (no data were available on the effect of

population, individuals who were homeless or previously homeless, and individuals with SMI who were enrolled in the Center for Mental Health Services' (CMHS's) Automated Community Connection to Economic Self-Sufficiency (ACCESS) program, in homeless services and shelters

homeless in adulthood (after adjusting for demographic factors) increased for those who had both neglect and abuse histories but decreased for those who had only one or the other. More

a 2.03 greater likelihood, and sexual abuse in adulthood with a 2.45 times greater likelihood (Kim, Ford, Howard, & Bradford, 2010).

For people who are homeless and have a substance use disorder, rates of childhood trauma (physical or sexual abuse) are especially high. Cohen and Stahler (1998) conducted indepth ethnographic interviews with 31 out-of-treatment African American men who used crack cocaine and were homeless. Most reported childhood trauma (typically involving exposure to physical and emotional interpersonal violence) often connected to gang activity. Research on African American women who used crack cocaine and were not in treatment found that women who were homeless (n=219) were significantly more likely than those who were housed (n=464) to have suffered physical abuse (42 percent versus 25 percent) and sexual abuse (40 percent versus 27 percent) before age 18 (Wechsberg et al., 2003).

In a study of both men and women living in shelters or on the street, having a substance dependence disorder was associated with higher rates of physical and/or sexual abuse, residential instability, and out-of-home placement in childhood and adolescence (Booth et al., 2002). This study assessed 1,185 people who had spent at least 1 of the past 30 nights in a temporary shelter or a setting not designed for shelter. Compared with those who did not have substance use disorders, people who reported a lifetime history of a substance dependence disorder reported higher incidences of physical and/or sexual abuse as children than people who reported never having a substance dependence disorder (12 percent of those with a lifetime diagnosis of alcohol dependence, 20 percent of those of those with a lifetime diagnosis of drug dependence, 17 percent of those with a lifetime diagnosis of alcohol and drug dependence, and 11 percent of those who had no substance dependence disorders reported this). People with a substance dependence disorder were also more likely to report violence or abuse in their homes as children that was not necessarily directed at themselves (17 percent of those with a lifetime diagnosis of alcohol dependence, 20 percent of those with a lifetime diagnosis of drug dependence, 23 percent of those with a lifetime diagnosis of alcohol and drug dependence, and 13 percent of those who had no substance dependence disorders reported this).

Trauma rates among people who are homeless in treatment populations

People who are homeless and in treatment for behavioral health disorders report high rates of trauma. Christensen et al. (2005) examined the prevalence of lifetime trauma experiences in people who were homeless and admitted to a Jacksonville, FL, integrated behavioral health program for people with CODs. Over 1 year, 80 percent of people admitted to this program (n=78) acknowledged a history of physical and/or sexual abuse. Of this population, 100 percent of the women and 69 percent of the men experienced a life-altering traumatic event. Jainchill et al. (2000) found high abuse rates in men and women (N=487, 62 percent male) at three New York, NY, shelter-based therapeutic community (TC) programs. Among the men, 67 percent had been physically abused and 14 percent had been sexually abused. Among women, 77 percent had been physically abused and 58 percent had been sexually abused. Trauma history and psychopathology were highly correlated, especially for women. Sacks, McKendrick, and Banks (2008) found that 69 percent of their treatment sample of women with substance use disorders who were homeless (N=146) reported childhood emotional, physical, and/or sexual abuse. They

Hepatitis

Hepatitis B virus (HBV) and hepatitis C virus (HCV) are particularly common among people who are homeless and abuse substances. For example, the Rosenblum et al. (2001) study described in the "HIV/AIDS" section found a 32 percent prevalence of HCV antibodies in the sample they investigated. Nyamathi et al. (2002) investigated HCV rates among women who were homeless and their intimate partners (*N*=884, some of whom were housed). They found that 22 percent tested positive for HCV. People who used injection drugs had significantly higher rates of HCV (77 percent compared with 12 percent), as did people who had lifetime histories of alcohol abuse (30 percent compared with 15 percent), cocaine use (31 percent compared with 16 percent), methamphetamine use (32 percent compared with 21 percent), and who reported having been hospitalized for a mental disorder (35 compared with 21 rp1(of)3(e)4(f)3(or)3((b)-10-12(e)4(d pos)-1(2t) al

Women

VA estimates that 70 percent of veterans who are homeless have substance abuse problems and 45 percent have mental disorders (VA, 2007). Among veterans who are homeless and perceive a relationship between their military service and their homelessness, 75 percent state that the contributing factor was a substance abuse problem that began while they were in the military (Mares & Rosenheck, 2004). Research by Sosin and Bruni (1997) found that individuals who were homeless and had alcohol-related problems were more than twice as likely to be veterans as people who were homeless and did not have alcohol problems or people who were domiciled but did have alcohol problems. According to the NSHAPC, among those who are homeless, being a veteran increases the odds of having alcohol problems by 1.3 times (Dietz, 2007).

Tessler, Rosenheck, and Gamache (2002) used data from the ACCESS program (see the description in the "Assertive Community Treatment" section) for people with SMI to compare male participants who were veterans (n=1,252) with male participants who were not (n=3,236). They found that veterans were significantly more likely than nonveterans to have symptoms of alcohol dependence.

Most studies of veterans who are homeless focus on male veterans, but female veterans are also more likely to be homeless than other women, although rates of substance abuse and mental disorder severity do not appear significantly higher for female veterans who are homeless than for other women who are homeless (Gamache, Rosenheck, & Tessler, 2003). Other data indicate that veterans who are homeless may have worse treatment outcomes compared with other

substance abuse treatment programs in urban areas in 2003 and 2004, clients who were homeless were three times more likely to report income from illegal sources than were those who were housed and had low incomes (Eyrich-Garg et al., 2008). Among people who used injection drugs, being homeless or marginally housed was also associated with a significantly higher likelihood of receiving income from illegal sources (Coady et al., 2007).

In research with a group of 1,426 individuals in San Francisco who were homeless or marginally housed (defined as residing in low-cost residential hotels), 23 percent reported that they had been in prison at some point in their lives (Kushel, Hahn, Evans, Bangsberg, & Moss, 2005). Both substance use and previous hospitalization in a psychiatric facility were associated with increased odds of also having been in prison, with psychiatric hospitalization associated with a 1.41 times greater chance of being in prison, heroin use at some during one's life with a 1.51 times greater chance, lifeti

Some people cycle back and forth between chronic homelessness and temporary incarceration. Metraux and Culhane (2004) analyzed data from 48,424 people who were released from New

and mental disorders, those disorders were less common for these women than for women who were homeless and living without dependent children. According to research reviewed by Felix

Other research by Zima, Wells, Benjamin, and Duan (1996), conducted with 110 mothers with dependent children who were homeless, also found that these women were underserved by behavioral health service providers. In that study, 72 percent of the women had high levels of psychological distress, indicating a probable mental and/or substance use disorder, but only 15 percent received mental health treatment, and the majority of those individuals received such services through medical providers, not specialty mental health services.

Daily responsibility for one's children can significantly decrease entry into treatment. In general, people who are homeless are more likely to attend inpatient (than outpatient) substance abuse treatment programs (see the "Treatment Settings" section), which often do not allow children to remain with parents. Kertesz, Larson, et al. (2006) conducted a 2-year follow-up (median length of follow-up was 15 months) of 274 individuals who had completed a detoxification program; 61 percent of the sample had been homeless at least some of the time in the 5 years before entering the study. Those who lived with their children (regardless of homelessness) were approximately half as likely (OR=0.51) to report any treatment during follow-up or any mutual-help group involvement (OR=0.53). Those who attended treatment were significantly more likely to attend outpatient programs than inpatient/residential programs, probably because child care was provided at outpatient but not inpatient treatment facilities. Findings were similar for homeless and low-income housed groups as well as for male and female study subjects.

Older adults

Rosenheck, Bassuk, and Salomon (1999) observe that rates of older adults among the homeless population vary considerably according to the sample. Research by Hahn, Kushel, Bangsberg, Riley, and Moss (2006) suggests that the adult homeless population is growing older. Their study found that the median age of a sample of adults (N=3,534) who used homeless shelters in the San Francisco area between 1990 and 2003 increased from 37 to 46 years old. During that same period, the percentage of the sample over age 50 grew from 11 to 32 percent. This reflects national trends, as the percentage of Americans aged 65 years and older has increased steadily since the beginning of the 20th century (3.1 million in 1900 and 33.2 million in 1994) and is projected to increase even more after the year 2010 (Wan et al., 2005) as "baby boomers" enter retirement age.

Conversely, a HUD (2007) national survey showed that adults aged 62 years and older made up a smaller percentage of those who were homeless (2 percent) in 2005 than they did of the general population (15 percent). The authors speculated that this is due to older adults qualifying for public programs like Social Security, Medicare/Medicaid, and senior housing, making homelessness less likely.

A survey of older adults who were homeless in the Los Angeles area found that over two thirds were male, almost 40 percent had some education following high school, and 28 percent were veterans (Shelter Partnerships, 2008). Another survey from homeless shelters in St. Louis, MO, found that individuals who were aged 50 and older (n=89) who were homeless and marginally housed were, compared with those under 50 (n=511), significantly more likely to be male and White and to have an alcohol and/or drug use disorder (DeMallie, North, & Smith, 1997). However, in CMHS' ACCESS study (N=7,224) of people with SMI who were homeless, rates of

hypertension (43 percent compared with 22 percent of those under age 50) and musculoskeletal disorders such as arthritis (27 percent compared with 12 percent of those under 50), but not chronic respiratory conditions.

TIP 26, *Substance Abuse Among Older Adults* (CSAT, 1998d), contains helpful information on treating older adults in general. Preliminary research (Schonfeld et al., 2000) from a cognitive–behavioral substance abuse treatment program developed by VA for older adults (ages 60 and older) that has treated a large number of persons who are homeless (more than one third of the sample) suggests that this intervention is effective in helping people who complete the program obtain and maintain abstinence.

Cultural/ethnic groups

According to HUD (2007):

> Homelessness, like poverty, disproportionately afflicts minorities. About 59 percent of the sheltered homeless population and 55 percent of the poverty population are members of minority groups, compared with only 31 percent of the total U.S. population. African Americans constitute 12 percent of the total U.S. population but 45 percent of people who are homeless (p. 30).

Data from substance abuse treatment settings also indicate that people from non-White racial/ethnic groups are overrepresented among those who are homeless. For example, according to 2009 TEDS data, 29.9 percent of treatment admissions who were classified as homeless were African American (compared with 19.6 percent of those housed with independent living arrangements), 15.8 percent were Hispanic (compared with 12.9 percent), and 2.9 percent were American Indian/Alaskan Natives (compared with 2 percent) (HHS, SAMHSA, OAS, 2011).

However, the relationship of race/ethnicity, ethnic identity, and homelessness is not well understood. Gamst et al. (2006) explored the relationship of homeless status, ethnic identity, and ethnicity on functional impairment (examined with subscales of the Behavior and Symptom Identification Scale) of Latino (n=120), African American (n=88), White (n=123), and Native American (n=24) men and women who were homeless in Pomona, CA. Of the total sample, 41 percent currently used alcohol (36 percent of Latino participants, 47 percent of African American participants, 44 percent of White participants, and 33 percent of Native American participants), and 41 percent indicated that they currently or previously used some type of amphetamine (27 percent of Latino participants, 27 percent of African American participants, 63 percent of White participants, and 48 percent of Native American participants). Latino participants tended to be younger and less likely to report being victims of assault while homeless on the streets than other participants. Nearly half of the Latino participants were first-generation immigrants. Multivariate analysis of variance results for the entire sample suggested a statistically significant relationship between ethnicity and functional impairment, indicating that White and African American participants reported significantly worse functioning than Latino and Native American participants.

Among people with SMI, being African American is also associated with a significantly greater likelihood of being homeless, although Whites with SMI are more likely to be homeless than are Latinos or Asian Americans with SMI (Folsom et al., 2005).

Race/cultural background may also affect service delivery in complex ways. For example, the types of services people receive vary somewhat according to culture/race, but it is unclear to what extent this reflects institutional biases and/or different cultural attitudes toward services. Among people with SMI who are homeless, African Americans appear to make less use of mental health services than do Whites (Horvitz-Lennon et al., 2009), and African American

People with behavioral health disorders who are homeless may also need to be educated about the services available to them or be convinced that services can be effective for them. Freund and Hawkins (2004) found that more than half of a sample of people who were homeless in the Pittsburgh, PA, area (*N*=225) believed they were not eligible for substance abuse treatment services. Of those who reported having substance abuse problems, 42 percent said that treatment services had failed them before, usually because of a lack of continuing care and residential supports.

People who are homeless are often ready to accept services other than treatment first, and they may require assistance from outreach workers and case managers to access services that would otherwise be difficult to obtain. In a study in Buffalo, NY (Acosta & Toro, 2000), people who were homeless (*N*=301) rated safety, education, transportation, medical/dental treatment, affordable housing, and job training/placement as most important.

People who are homeless sometimes avoid behavioral health services because they view them as not helpful or respectful (Sosin & Bruni, 2000). The outreach worker or counselor, to be effective, must use the trusting relationship to guide the client to accept appropriate services and move at the client's pace (Wenzel et al., 2001). Often, a relationship must be established before the subject of treatment can be broached (Christensen, 2009).

Assertive outreach, however, can be successfully used to move people with substance use disorders who are homeless into treatment. In a small (*N*=73) study of people who had a primary diagnosis of a substance use disorder and were homeless, assertive outreach was successful in motivating 41 percent of the sample to enter treatment (Fisk, Rakfeldt, & McCormack, 2006).

Motivation for Treatment

Velasquez et al. (2000) found that a majority of people who were homeless and presented for services in a drop-in center (*N*=100) acknowledged that they drank (53 percent) or used drugs (71 percent) "too much" and had high levels of psychological distress (i.e., had a mean score on the Global Severity Index in the 93rd percentile for men and 97th percentile for women). Using the transtheoretical model (Prochaska, DiClemente, & Norcross, 1992), Velasquez et al. (2000) found that 54 percent of the people who reported alcohol use in the prior 6 months were in the precontemplation stage of change and 40 percent were in the contemplation stage. Among people who reported use of drugs, 30 percent were in the precontemplation stage of change and 60 percent were in the contemplation stage. Motivation for change requires that the individual want to change (e.g., problem recognition, desire for change) and believe that change is possible (e.g., be able to change, have access to treatment and other needed services and resources).

As noted in the prior section, for people with behavioral health disorders who are homeless, shifting motivation for behavioral health services can take time, and mental health workers may need to focus first on helping potential clients meet more immediate, instrumental needs. If appropriate services are not available, the worker or case manager should advocate in the community for services that better respond to the client's needs (McQuistion et al., 2008). Other factors that increase readiness for behavioral health treatment include accurate communication about the treatment program, its services, and its effectiveness; a considerate and respectful approach; affordable housing and medical and dental care; vocational services; and participants'

Orwin et al. (1999) also found that providing housing had the single greatest effect on improving retention. Burt and Anderson's (2005) evaluation of State-funded supportive housing programs for people with SMI in California supports this finding. They found the correlation of the percentage of clients housed and the percentage of clients retained by those programs to be 0.929 (see also the "Housing" section).

For women who are homeless and have children in their care, residential programs that allow those children to remain with the client are more likely to retain those clients than programs where women are separated from their children. Research conducted largely with women with children who were not homeless has found this to be the case (for more information, see TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* [CSAT, 2009d]). One study conducted with women who were homeless also appears to confirm it. Smith, North, and Fox (1995) compared an outpatient treatment program—where women attended treatment during the day with their children but had to find their own housing (with or without their children) after treatment concluded (n=82)—with a residential TC program where women lived on site with their children (n=67). The clients assigned to day treatment were more likely to miss their first session and to drop out once treatment began. However, dropout rates were high for both groups, with 75 percent of the nonresidential group and 50 percent of the residential group leaving by week 12 of the 1-year program. Supportive housing programs that allow single parents with SMI to stay with children are also becoming available, and one such program suggests that it is having a positive effect on both parents and children (Emerson-Davis Family Development Center, 2000); however, formal evaluations of such programs have been and remain a challenge (Nicholson, Hinden, Biebel, Henry, & Katz-Leavy, 2007; O'Campo et al., 2009).

Other research indicates that, among veterans who were homeless when they entered a program that combined substance abuse treatment with social and vocational rehabilitation (N=596), women were more likely to be retained in treatment than men, and those who were younger (i.e., in their 20s) were more likely to be retained in treatment than those who were 50 or older (Justus, Burling, & Weingardt, 2006). People with depressive disorders had higher retention rates than those without, whereas those with current personality disorders had lower rates.

Stahler, Cohen, Greene, Shipley, and Bartelt (1995) interviewed men who were in substance abuse treatment, diagnosed with cocaine use disorders, and homeless. The men rated sobriety as their primary indicator for treatment success. They also endorsed being better able to deal with emotions, handle money, take responsibility for their own lives, handle stress, develop and pursue personal goals, get and hold a job, find and stay in housing, and have a more positive self-image. Client and program attributes endorsed by both clients and providers were (in order of

Behavioral Health Interventions

A wide range of evidence-based treatment modalities and interventions are available to aid in the treatment of people who are homeless and have behavioral health disorders. Many of these interventions are applicable regardless of whether the clients have substance use and/or mental disorders. A few interventions specific to mental health or substance abuse treatment settings are also discussed in the “Treatment Settings” section. The discussion in this section highlights only

Intensive case management

ICM effectively engages people who are homeless into services that would otherwise be difficult to access. ICM includes assertive and persistent outreach, reduced counselor caseloads, participant-set priorities, development of trusting relationships, and active assistance in accessing needed resources. The case manager (or counselor, as appropriate) follows the client through transition into services and provides support until the client is able to function either independently or in mainstream services without ICM support. See TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT, 1998a), and TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c), for more information on ICM services.

As discussed in the "Assertive Community Treatment" section, when high-quality, integrated clinical case management services and appropriate community resources are available, ICM for people who are homeless can be as effective as ACT (Essock et al., 2006). However, according to a review by Nelson, Aubry, and Lafrance (2007), the sizes of effects on housing for ICM interventions are smaller than those seen with ACT interventions, and both are smaller than supportive housing interventions.

Morse (1999) outlines four reasons why providers consider ICM an important service for people who are homeless:

1. People who are homeless have multiple, often extensive, unmet needs.
2. The services needed by people who are homeless are often delivered through a fragmented system of care involving multiple providers.
3. The structure of the service system often presents barriers for people who are homeless, making it even more difficult for them to access services.
4. Case managers are able to facilitate access to services and coordinate services from multiple providers in ways other staff might not be able to or have time for.

Kilbourne et al. (2002) found that women who were homeless (N=974) and had a case manager were less likely to inject drugs than those who had no case manager. Another study found that people diagnosed with alcohol dependence who were chronically homeless or at high risk of homelessness and had a case manager demonstrated improved income from public programs, increased number of nonhomeless nights, and decreased number of days drinking (Cox et al., 1998).

Adding ICM to behavioral health services that have readily available, easily accessed, comprehensive services was found to have little effect on treatment outcomes. This suggests that such services may have a greater impact in environments featuring available, but not easily accessed, services (Braucht et al., 1995; Conrad et al., 1998). Rosenheck (2010) reviewed a few studies that demonstrate that ICM is usually cost effective when used with people with behavioral health disorders who are homeless.

Critical time intervention

Critical time intervention (CTI) is an evidence-based ICM approach developed by Susser et al. (1997) to assist clients in the transition from shelter to community. CTI emphasizes the case

Kenny et al. (2004) compared ACT (*n*=105) and brokered case management (*n*=60) for people with SMI who were homeless; they also explored possible mediating or moderating factors related to ACT outcomes. Participants who received ACT had better outcomes in terms of housing and mental disorder symptoms. Housing outcomes were partially mediated by case management assistance with housing and financial assistance, but none of the mediating or moderating factors the researchers evaluated had a significant effect on mental disorder symptom outcomes.

In ACT, the appropriate level of service intensity depends on the participant's needs and the accessibility and availability of integrated services in the community. In a randomized trial, Essock et al. (2006) compared ACT and integrated intensive clinical case management. Participants (*N*=198) were homeless and diagnosed with a major psychotic disorder and an active substance use disorder; they had high levels of medical/mental health service use and poor independent living skills. ACT team services were similar to those previously described and had a staff–participant ratio of 1:10 or 1:15. The intensive clinical case management teams comprised clinicians from different disciplines and had individual caseload ratios of about 1:25. The two conditions were equally effective at reducing substance use after 3 years, with about one third of all participants achieving substance use remission. ACT services reduced hospitalization significantly at the site that had higher hospitalization rates. The authors suggested that the findings were affected by the quality of the community programs at both sites and the incorporation of many ACT values and techniques into the intensive clinical case management services. They concluded that the structure of service delivery is less important than developing and maintaining necessary skill sets among treatment staff. However, ACT is the preferred integrated treatment delivery model when high-quality, integrated clinical case management services and appropriate community resources are lacking.

associated with the use of significantly more services, and certain types of support (e.g., greater contact with one's family of procreation) were associated with significantly more frequent use of certain types of services (e.g., medical services).

Zlotnick, Tam, and Robertson (2003) followed 397 individuals who were homeless for a 15-month period and found that support from family, friends, and social services shortened the course of homelessness, but only for people who did not meet diagnostic criteria for a current substance use disorder. The authors speculated that current substance use interferes with the

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treatment program, the addition of peer mentors (drawn from African American churches and other faith communities) improved retention, client satisfaction with the program, and long-term abstinence (according to]/Subless

and storing medication once it is obtained (Morrison, 2007). Gilmer et al. (2004) found, in an analysis of 2 years of Medicaid data for 2,801 individuals with schizophrenia, that being homeless was associated with the lowest adherence rate (only 25.9 percent of those who were homeless adhered to prescribed regimens) of any of the variables they analyzed.

Helping clients who are homeless obtain insurance benefits (see the "Help Obtaining Public Assistance" section) can significantly reduce barriers to medication compliance (Kushel, Vittinghoff, & Hass, 2001). Providing treatment that helps clients manage housing and other service needs may also improve adherence. Dixon, Weiden, Torres, and Lehman (1997) looked at medication adherence among a group of 77 people who were homeless and had SMI before and after they entered an ACT program. Although 29 percent adhered to medication regimens before entering the program, that percentage increased significantly to 57 percent 3 months after program entry and fell only slightly from the 3-month level at 1 year after entry.

Supported housing environments also appear helpful in promoting medication adherence. Magura et al. (2002) found a significant association between supportive housing and adherence in their study of 240 individuals with CODs attending Double Trouble in Recovery meetings. Velligan et al. (2010) reviewed findings from an expert clinical survey regarding treatment adherence for people with SMI, which, although not specific to clients who are homeless, may be helpful in making decisions about medications for this population. For clients with severe psychotic symptoms who are consistently noncompliant with medication regimens, providers can consider outpatient commitment (Torrey & Zdanowicz, 2001) or the use of long-acting, injectable antipsychotics (Velligan et al., 2010).

Medications for sig

information from focus groups with people who were homeless and smoked (*N*=62), found that about 44 percent of subjects had used nicotine replacement products in the past and 15 percent had previously used bupropion (Okuyemi et al., 2006). Participants were interested in using pharmacological aids for smoking cessation, but their preferred medications varied according to

programs available (Finney & Monahan, 1996; Holder, Longbaugh, Miller, & Rubonis, 1991; Miller & Hester, 1995).

Smith et al. (1998) compared a 3-month CRA program for people who were homeless and diagnosed with alcohol dependence (*n*=64) with a standard shelter-based program (*n*=42). The shelter-based program was a day shelter offering basic meals, clothing, showers, a job program, individual sessions with AA-oriented counselors, and onsite AA meetings. Participants in the CRA condition were treated in a group therapy format, and two weekly prizes were awarded for good attendance. The focus of most groups was skills training, primarily in the areas of problem-solving, communication, and drink refusal. Periodically, group sessions were supplemented with relationship counseling or case management meetings. Participants in the CRA condition were housed in grant-supported apartments, and those who were employed at the end of 3 months were allowed to remain in the apartments for an additional month. Housing privileges were suspended temporarily if random breathalyzer tests detected drinking. Compared with standard care at the shelter, those treated with CRA showed significantly better outcomes throughout a year of follow-up. Participants in the community reinforcement intervention had fewer drinks per week, fewer days of drinking per week, and a lower peak blood alcohol content rating. However, few differences in employment or housing outcomes were observed.

Other Services

People who are homeless have a wide range of often pressing needs, which may need to be addressed in order to improve treatment retention and outcomes. This section discusses some of the services that might lie outside traditional mental health and substance abuse treatment services. Note that housing services are discussed separately (see the “Housing” section).

Occupational Therapy

As Muñoz, Garcia, Lisak, and Reichenbach (2006) note, the importance of an occupational therapy (OT) perspective in services for people who are homeless is now well recognized. Citing research with this population, they argue that “occupational therapists are well-suited to provide core services at homeless shelters” (p. 136). These services may be especially salient for clients with behavioral health disorders.

(*N*=1

individuals. Although this study was not limited to people with behavioral health disorders, rates of substance use were high but comparable for the homeless and domiciled samples; self-reported histories of mental health treatment, while less frequent, were also comparable.

Bird et al. (2002) found the same level of need for public services in people who were homeless

Interventions to help prevent mental disorders in the children of families who are homeless include ones that improve parenting skills and redu

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Safety, and Services Project, which provides medical and behavioral health services to people with CODs in a "Safe Haven" shelter specifically designed for this use (see the description in Lincoln, Plachta-Elliott, & Espejo, 2009).

Yet another alternative to inpatient treatment for people with mental disorders who are homeless is supportive housing, which provides housing as well as a lower intensity of services. Supportive housing encompasses a range of levels and types of service (Corporation for Supportive Housing, 2006; HUD, 2001). (See the description in the "Supportive Housing" section.)

Substance Abuse Treatment Settings

Various substance abuse treatment services are available for people who are homeless, and (as noted in the "Prevalence of People Who Are Homeless in Behavioral Health Settings" section) members of this population use such services at higher rates than people who are housed. A few specific settings that incorporate housing and treatment are discussed here and in the "Supportive Housing" section. For clients with CODs, substance abuse treatment may also improve mental health. In a study of 95 people who were cocaine dependent and homeless, treatment participation was associated with significant reductions in mood and anxiety disorders (Kertesz, Madan, Wallace, Schumacher, & Milby, 2006).

Postdetoxification stabilization programs

People who are homeless have been found to be more likely to enter a detoxification program than people who are housed. According to 2009 TEDS data, 47.1 percent of treatment admissions for people who were homeless were to detoxification programs compared with 18.9 percent for people who had independent living arrangements (HHS, SAMHSA, OAS, 2011).

to enter residential or inpatient treatment than outpatient treatment. Kertesz, Larson, et al. (2006) found that homelessness was associated with increased use of residential treatment services.

Little information is available comparing inpatient/residential and outpatient substance abuse treatment services for people who are homeless, but in a study in which people with SMI (i.e., schizophrenia and/or affective disorders) and co-occurring substance use disorders were randomly assigned to a residential treatment program (*n*=67) or an outpatient program with a similar design, retention rates were significantly higher for the residential program (Burnam et al., 1995). The authors also found better outcomes at an assessment 3 months after beginning the

De Leon et al. (2000) compared two different types of MTC programs and a treatment-as-usual control group (involving a variety of treatment options) for clients who were homeless. The second MTC program involved more freedom for clients, participation outside the TC at a day treatment program, reduced client responsibilities related to program operations, and more direct assistance to clients from staff. The researchers found that clients in both MTC groups had significantly better outcomes for substance use, criminal activity, HIV/AIDS risk behaviors, and psychological dysfunction than did individuals in the control group at 1 and 2 years after assessment, with the second MTC model providing the best outcomes.

Egelko et al. (2002) found that an MTC approach for people who were homeless with CODs produced significant improvements in all measured psychological symptoms between intake and third

Schumacher, 2008). BDT+ can be implemented more easily in urban clinical settings where core components of contingency-managed behavioral day treatment already exist.

To examine whether housing without an abstinence contingency (non-abstinent-contingent housing [NACH]) plus effective day treatment would be sufficient for improved outcomes, Milby, Schumacher, Wallace, Freedman, & Vuchinich (2005) compared NACH (n=67), ACH (n=63), and a control group that received no housing (NH) (n=66). All three conditions received all other elements of the day treatment. Participants had cocaine dependence and co-occurring nonpsychotic mental disorders and were randomly assigned. Intention-to-treat analyses suggest that ACH increased abstinence compared with NACH and produced an even greater increase compared with NH. Because the NACH clients had more incentive for attendance—in that there were no negative consequences for drug-positive urine tests—their attendance was higher than

More data on supportive housing came from 734 participants in the Federal Collaborative Initiative to Help End Chronic Homelessness (CICH), who received supportive housing that included substance abuse treatment, medical care, and mental health treatment (Mares & Rosenheck, 2010). At an assessment 1 year after entry into the study, participants showed significant improvements in mental disorder symptoms (according to Brief Symptom Inventory scores) and housing outcomes but not in substance abuse outcomes.

programs and a standard control group for 260 individuals with SMI who were long-term users of shelter services found that individuals were more likely to obtain stable housing in the Housing First programs and that, at 2 years into the study, 84 percent of clients in Housing First were stably housed (Stefancic & Tsemberis, 2007).

In Housing First programs, supportive services are generally available 24 hours a day, 7 days a week, to help clients stay in their housing. This approach produces better long-term housing outcomes for this population than traditional models of mandatory treatment followed by referral to permanent housing. For example, in a comparison of traditionally accessed supportive housing based on perceived "housing readiness" with a Housing First program combining scattered-site housing and ACT team services, 88 percent of 240 people (all with mental disorders and half with CODs) receiving Housing First remained housed after 5 years compared with 47 percent of those in the traditional care system (n=1,600) (Tsemberis & Eisenberg, 2000).

Tsemberis et al. (2004) compared a Housing First option with housing that was contingent on entering treatment and remaining abstinent for people who were homeless and diagnosed with CODs. Participants in the Housing First program entered stable housing significantly faster and had more days in stable housing. There were no significant differences in the level of substance use between participants in the two programs, but the group in the enforced abstinence program did attend more treatment sessions. Padgett, Gulcur, and Tsemberis (2006) compared outcomes from a Housing First program and a "treatment first" program serving people who were homeless and diagnosed with CODs. They found individuals in the Housing First program had significantly better housing outcomes but found no significant differences on outcome measures of alcohol and drug use at 48 months (Padgett et al., 2006). In another study of 95 participants enrolled for 1 year in a Housing First program, Larimer et al. (2009) tracked regular decreases in drinks per day (from a median of 15.7 at baseline to 10.6 at 1 year) and in days spent drinking to intoxication (from a median of 28 out of 30 at baseline to 10 out of 30 at 1 year) for individuals with severe alcohol use disorders, but changes did not rise to the level of significance, and problems with self-reported data may have confounded results.

Another study, which compared Housing First (n=99) with a Continuum of Care program that had treatment and sobriety requirements for housing for clients with SMI (recruited from either psychiatric hospitals or through street outreach), found that Housing First was associated with -2(c)4(h)-10(c)4(

On the other hand, some researchers have found no significant changes in substance use or mental disorder symptom severity associated with participation in Housing First programs (Pearson et al., 2009); others have found no significant differences from control groups following participation in Housing First programs (Padgett et al., 2006; Sadowski, Kee, VanderWeele, & Buchanan, 2009; Tsemberis, Gulcur, & Nakae, 2004;). Kertesz et al. (2009) cautioned that, in their review of Housing First studies, they were unable to identify programs that included people with severe substance use disorders and that many of the studies (including some of those mentioned here) did not use rigorous methods to assess substance use (e.g., relied on self-report).

Stefancic and Tsemberis's (2007) research compared two Housing First programs. One provider, Pathways to Housing, was new to the suburban county where the study was conducted; the other provider was a newly formed consortium of local treatment and housing agencies that had no experience in Housing First programming. After 4 years, Pathways to Housing retained 78 percent of people in housing; the consortium retained 57 percent. Pearson et al. (2009) also found large differences in nights spent in housing

average cost per week of abstinence favored the less expensive standard treatments in all but one comparison. However, the average incremental cost per week of abstinence was not large for the enhanced treatments. The authors concluded that policymakers should consider enhanced treatments that reduce homelessness (e.g., include ACH) because the incremental costs are reasonable and can lead to positive outcomes not measured in this study.

Stecher, Andrews, McDonald, and Morton (1994) found that although daily operating costs were 35 to 45 percent higher for residential services, the cost associated with successful treatment completion was about the same for either residential or outpatient settings.

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