1996

Performance in community living skills by persons who are homeless and mentally ill

Rachel Ann Brady
San Jose State University

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**PERFORMANCE IN COMMUNITY LIVING SKILLS
BY PERSONS WHO ARE HOMELESS AND MENTALLY ILL**

A Thesis

Presented to

The Faculty of the Department of Occupational Therapy

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science

by

Rachel Ann Brady

December, 1996

UMI Number: 1382552

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APPROVED FOR THE DEPARTMENT OF
OCCUPATIONAL THERAPY

Lela A. Llorens, Ph.D., OTR, FAOTA

Carolyn Glogoski, MS, OTR

Elizabeth Cara, MA, OTR

APPROVED FOR THE UNIVERSITY

ABSTRACT

PERFORMANCE IN COMMUNITY LIVING SKILLS

BY PERSONS WHO ARE HOMELESS AND MENTALLY ILL

by Rachel A. Brady

The purpose of this study was to determine specific problem areas in a sample of homeless mentally ill based on performance and self-report. This is a non-experimental research study that employed analytical and descriptive survey methods. The Scorable Self-Care Evaluation (SSCE) was administered to fifteen homeless mentally ill subjects and fifteen "normal" subjects. Comparison of the SSCE scores indicated that subjects in the homeless mentally ill group had significantly lower total scores and lower scores on three of the four SSCE sub scales. A semi-structured interview was conducted with the homeless mentally ill subject group. Subjects reported housing, employment, and money as their three greatest needs. Seven predominant themes were identified in the subjects' descriptions of how homelessness had affected their physical and mental health. Findings in this study underscored the uniqueness of the homeless mentally ill population and identified areas for potential intervention by occupational therapists.

Acknowledgments

I can hardly believe that I am writing this page! It has been a long road since first beginning this study back in 1992 but I have learned so much along the way and have many people who have partnered with me in this endeavor. First of all, I need to thank God for the strength and discipline He has given me to carry out this work. I think of Philippians 1:6, which states "He who began a good work in you will carry it on to completion until the day of Christ Jesus." I am so very grateful to Him for bringing me to this point of completion.

Many people have been part of the process and I would like to mention as many as I can remember! I was honored to have Dr. Lela Llorens as my advisor and I want to thank her for all of the time she gave and patience she showed to me throughout the thesis process. I am very grateful for Carolyn Glogoski, the principal investigator of this study, for whom I was a research assistant. Thanks also to my second reader, Elizabeth Cara, whose course in psychosocial practice was foundational to this study. Thanks to my research partner and fellow graduate student, Dave Rose, without whom I could not have collected the data for this study. I am grateful for the cooperation and participation of the persons who agreed to be subjects for this study. The staff and clients at the Spring Street Shelter in Redwood City were all wonderful to work with. Thanks also to my friends from the former Vineyard Christian

Fellowship of San Jose who participated so willingly in this study.

As I have attempted to take each necessary step leading to completion of this thesis, there have been those who have offered me assistance and flexibility that has been crucial to the process. I appreciate so very much the flexibility in my work schedule offered to me by my supervisors Michele Berro and Sarah Kelly at Rancho Los Amigos Medical Center in Downey, California. Thanks also to Nancy Sores-Corson, a co-worker at Rancho Los Amigos who has offered me advice on qualitative research and reviewed the transcripts of my interviews. Jean Koketsu, a friend from the occupational therapy program who lives in San Jose, has been so gracious to me by assisting with administrative tasks that I was unable to carry out from southern California. I am indebted to Brian Arsenault, a friend from my church who shared his knowledge of computers with me as I prepared overheads for the oral presentation of this study and again as I sought to edit and print the final copy of the thesis. Finally, I want to thank my parents, sister, and friends, especially those at Celebration Community Church in Costa Mesa. God has used all of you to bless me with encouragement and prayers that have served to strengthen me and bring me to the end of this journey.

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CHAPTER 1

INTRODUCTION

PURPOSE

The purpose of this study was to determine specific problem areas in the performance and self-report of performance in a sample of persons who are homeless mentally ill. The primary aspects of this purpose were report the effects of homelessness on the physical and mental health of homeless mentally ill persons and to report self-perceived needs for service identified by these individuals. A secondary related aspect was to determine whether differences exist in the performance of living skills between homeless persons who are mentally ill and the normal population.

STATEMENT OF THE PROBLEM

Homeless people represent a diverse and population characterized by complex problems (Stephens, Dennis, Toomer, & Holloway, 1991). There exists a need for comprehensive strategies in evaluation and intervention services to most effectively address such diversity (Levine & Rog, 1990). Specific differences in the physical health status and related treatment needs of the homeless have been identified (Gelberg, Linn, Usatine, & Smith, 1990). Similarly, diagnostic psychological differences, such as higher rates of depression among the homeless have been reported (Ritchey, La Gory, Fitzpatrick, & Mullis, 1990). With this finding, it was suggested that such

alterations in mood may limit the homeless person's ability to resolve their homeless situation even if housing and opportunities were available.

The National Institute of Mental Health has that between 28 to 37 percent of the homeless population also suffer from some type of mental illness (Morrissey & Dennis, 1986). The factors contributing to this situation are currently under debate. The initial and most held view in the field of psychiatry is that the deinstitutionalization legislation of the 1960s was the primary event that brought about the plight of the homeless mentally ill. As state mental hospitals were closed and the patients were given over to their communities for support, many were unable to live in an unstructured environment where food, clothing, shelter, and access to medication were not provided (Belcher & Toomey, 1988). In contrast, Cohen and Thompson (1992) argue that the socioeconomic and political problems that led to an overall increase in homelessness are more significant than deinstitutionalization when viewing the homeless mentally ill. Thus, factors such as the decline in low-income housing and cuts in social welfare benefits should be considered as causes of homelessness among the mentally ill.

The National Institute of Mental Health (NIMH) has made efforts since 1982 to encourage research and assist individual states and communities in providing care to the homeless mentally ill (Levine & Rog, 1990). However, the overall number of actual services provided specifically for the homeless

mentally ill are few. These individuals are often excluded both from services available to the general homeless population as well as from services for the mentally ill population (Hildner & Block, 1990). Lamb (1990) expresses the concern of those aware of this crisis as he advocates for immediate provision of extensive case management and other needed services for this population.

The discipline of occupational therapy has not played a major treatment role with the homeless mentally ill in the community setting. By definition, occupational therapy is concerned with enhancing a person's performance of tasks and roles essential to productive living in the environment (Hopkins & Smith, 1988). In order to work toward enhancing a person's task and role performance, the existing level of performance must be known. Currently, there is little known about the performance levels of the homeless mentally ill in the community. In addition, there is controversy over distribution of limited funding for mental health services.

Health care professions will have greater responsibility to assist policy makers in making decisions to allocate these scarce resources appropriately (Dennis, Buckner, Lipton, & Levine, 1991). The possibility that the discipline of occupational therapy could play a role in intervention and advocacy for the homeless mentally ill population raised the issue of appropriate programming. This study was designed to explore factors that can be

considered in this effort in order to develop appropriate treatment programs for this unique population.

RESEARCH QUESTIONS

The research questions generated for this study are:

1. Is there a difference in the performance of community living skills between homeless mentally ill and the normal population?
2. What are overall performance assets and liabilities of homeless mentally ill persons?
3. What do homeless mentally ill persons identify as their greatest needs?
4. How do homeless mentally ill persons describe the effects of homelessness on their physical and mental health?

DEFINITIONS

The following definitions were used in this study:

Operational:

Homeless: Persons lacking permanent housing

Homeless mentally ill: Persons lacking permanent housing and having any condition described in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM III-R) (American Psychiatric Association, 1987).

Normal population: Persons possessing permanent housing and who do not meet the diagnostic criteria for any condition described in the DSM III-R.

Community living skills: Abilities in the areas of personal care, housekeeping, financial management, work, and leisure that lead to self-maintenance and independent living, as evaluated by the Scorable Self-Care Evaluation (SSCE) (Clark & Peters, 1984)

Conceptual:

Performance: Operation or functioning

Asset: Area of high performance

Liability: Area of low performance

Physical health: Condition of body

Mental health: Condition of mind

ASSUMPTIONS

Assumptions made by the researcher were that the subjects would be able to speak, read, write, and understand English; would attempt to follow the directions given to them to the best of their ability; would be able to sustain attention throughout the evaluation process and complete all procedures involved; and would be available at the scheduled time of data collection and at a later date, if necessary.

As a part of this research, it was further assumed that community living skills are significant and are useful in determining and individual's ability to live independently. Performance on a structured self-care evaluation can be an indicator of an individual's actual performance skills.

Hearing and considering client's perspectives regarding their situations is important in understanding their needs.

LIMITATIONS

The homeless mentally ill sample in this study was one of convenience as it consisted of people who resided at an established shelter. This limits the results to homeless persons who utilize shelters. The small sample size and inability to exactly match age and gender of the homeless mentally ill group with the "normal" group are other limitations.

The Scorable Self-Care Evaluation (SSCE) (Clark & Peters, 1984) does not report normative data for psychiatric populations. In addition, some subtests of the SSCE only simulate the task being evaluated and thus may not be reliable as indicators of actual performance. It may be questioned whether an evaluation administered in a preplanned setting is a reliable indicator of actual performance in a community setting.

SIGNIFICANCE OF THE STUDY

Objective assessment of community living skills in the homeless mentally ill population is an area not widely addressed in the current literature. The perspectives and treatment priorities of homeless mentally ill individuals also has not been extensively explored. This study involves both of these areas. This study considers the role that occupational therapy might play as part of the treatment team for the homeless mentally ill and

establishes a basis for further occupational therapy research with this population. It may also contribute to the development of programs appropriate to the needs of the homeless mentally ill. This study expands the area of occupational therapy theory by applying existing theory to a population not addressed in the occupational therapy literature. Similarly, it contributes to practice by providing implications for expanded community treatment opportunities. Hopefully, implications for public policy specific to the homeless mentally ill population will also result from this study.

CHAPTER 2

REVIEW OF THE LITERATURE

The following literature review will first discuss the frame of reference that guided the present research. The uniqueness of the general homeless population as well as the homeless mentally ill population will then be described. The various events and factors attributed to generating the homeless mentally ill population will be presented. Finally, evaluation and intervention with the homeless mentally ill population will be discussed.

Frame of Reference

The Model of Human Occupation is the frame of reference from which this study will be viewed. The Model identifies human beings as open systems that interact with their environments by receiving, processing, and responding to stimulation (Oakley, Kielhofner, & Barris, 1985). Three subsystems exist in this model: volition, habituation, and performance. Volition refers to the innate urge one has to explore the environment. Habituation is based on the idea of maintaining a daily routine through the use of habits and roles. Performance produces action and consists of skills. The performance subsystem will be focused specifically in the area of community living skills and will seek to examine performance abilities in persons who are homeless and mentally ill. Barris, Kielhofner, & Watts (1988) give the following description of disorder in performance components

of mentally ill persons: "Mentally ill ... have been observed to have deficits in such process skills as problem solving, planning, anticipating consequences, organizing objects in space and sequencing behaviors" (p. 51). These performance skills must be functional in order for a person to live successfully in the community. Thus, a person with performance deficits may be more likely to become homeless. However, if such deficit areas can be treated, a person's performance component may become more functional and lead to more successful living in the community.

Background on the Homeless and Homeless Mentally Ill

The homeless are a unique population with specialized needs and circumstances affecting physical and mental health. Gelberg, Linn, Usatine, and Smith (1990) conducted a survey and compared the physical health status of homeless clinic users with the other clinic users. The results showed that the homeless were more likely to have functional limitations, dermatological problems, chronic obstructive pulmonary disease, vision problems, social isolation, foot pain, and tooth decay.

Gelberg, Stein, and Neumann (1995) conducted a study to objectively estimate undernourishment among homeless adults in Los Angeles County. By way of introduction to their study they noted the circumstances that the homeless population faces in attempting to meet their needs for acquiring and preparing food. It was noted that the homeless often are unable to afford

high-quality food and because of lack of access to cooking facilities and storage areas they are dependent on fast food and pre-packaged food. In addition, the free sources of food such as soup kitchens and shelters often offer only one or two meals a day and therefore do not allow a homeless person to establish normal routines for eating meals. The study found that thirty-three percent of the sample was undernourished.

Factors found to be predictors of undernourishment were homeless persons who were male, used drugs, had less utilization of free food sources, or had less income. Recommendations from this study included life skills training in the areas of meal preparation and shopping and vocational rehabilitation with the goal of increasing employment opportunities for this population. Another recommendation was a greater number of drug and dual diagnosis treatment programs for the homeless.

In addition to differences in physical health, the homeless population has been found to have differences in the area of mental health. Ritchey, La Gory, Fitzpatrick, and Mullis (1990) administered the Center for Epidemiological Studies (CES) Depression Scale to homeless, community-wide, and psychiatric patient populations. Approximately four times as many persons from the homeless sample met the criteria for clinical depression than those in the other two sample groups. Mental illness was also reported as one of the six most common diagnoses found among homeless

people being treated as part of the Health Care for the Homeless Program sponsored by the McKinney Act in 1988 (Hildner & Block, 1990).

Schutt, Meschede, and Rierdan (1994) examined the prevalence of and relationships between distress, suicidal thoughts, and social support among homeless adults in three Boston shelters. The homeless sample reported a depression rate over twice as high as that of the normal population. Thirteen percent of the homeless sample reported having had suicidal thoughts in the past month. Social support was found to be a significant factor in how homeless individuals responded to distress. Those who felt they had social support were less distressed and less likely to have suicidal thoughts than those with less social support. It was also noted that increased distress levels were associated with drug abuse but not alcohol abuse. Recommendations were made for further research in order to evaluate the influence of social support on homeless persons. In addition, more specific examination of the problems with drug abuse in this population was encouraged.

Harris, Mowbray, and Solarz (1994) evaluated physical and mental health and substance abuse problems of shelter users in Detroit. The most prevalent physical problems noted in this population were dental and vision problems. Twenty-six percent of the sample had a history of psychiatric hospitalization and roughly sixty percent of these hospitalizations had been within the past two years. Distress measures were positively correlated with

substance abuse. In addition, persons taking psychotropic medication were found to have a greater history of alcohol abuse. The authors encouraged an interdisciplinary approach to service for this population in order to address the variety of needs found. The disciplines of social work, substance abuse counselors, physical health specialists and vocational rehabilitation specialists were listed as those that may offer meaningful intervention to the homeless population.

A few studies have sought to obtain the perspective of homeless persons themselves in order to have direction in developing intervention. Neubauer (1993) stated "A first step toward integrating homeless persons into the process of planning for appropriate housing is to ask them about their housing preferences" (p. 492). Neubauer (1993) pointed out that homeless people who use shelters find that their daily routine is dictated by the schedule of the shelter and thus they are further alienated from society. In efforts to know actual housing preferences of the homeless population, Neubauer conducted a survey of shelter users in Maryland. Results of the survey showed that more than half of the respondents stated that they preferred to live alone in either an apartment or private home. Nineteen percent responded that they would prefer to share either an apartment or home with a roommate. Three and a half percent of the respondents stated that they preferred to stay in shelters.

Elias and Inui (1993) conducted semi-structured interviews with homeless men at a public shelter in Seattle. The purpose of the interviews as to obtain insight into the perspectives of these men on topics such as shelter, employment, health, family, safety, social services, and alcohol use. The information gathered in the interviews was complex. The need for shelter in general involved underlying needs for safety, support, privacy, community, and locality. These men reported difficulty in finding affordable housing as well as difficulty finding work that paid an adequate wage to afford housing. Some limitations to employment that they reported were having a physical disability and being unable to compete for work due to aging. Incidence of violence and crime in their lives was high and the influence of substance abuse over their behavior was significant. The men frequently explained that drinking was often associated with loneliness or the need to be with people and the bar was the only setting that met this need.

However, shelters met this need to some extent. In shelters that encouraged sobriety the men described a sense of support and community that they did not have when they were alone. Yet shelters were recognized as only temporary solutions for someone dealing with addiction and loneliness. Most shelters require that the residents leave the premises during the day and thus these individuals are faced with occupying their time until they are able to return in the evening. The men in the Elias and Inui (1993) study

reported that this situation led them to only look at short term activities instead of develop long term goals.

The view of self that the men had was influential over their initiation of personal hygiene and utilization of social services. As their self-perception declined so did their ability to initiate hygiene activities and access community resources. The authors of the study stated that recognizing the experiences of homeless persons would be useful in developing meaningful interventions and public policy to assist this population.

Diblasio and Belcher (1993) addressed the issue of self-esteem with homeless persons, pointing out that the inability to obtain basic necessities or living can lead to feelings of failure and poor self-esteem. This impairment in self-esteem can become a barrier for homeless persons' functioning in activities of daily living, decreasing their motivation for seeking employment and housing. The authors also noted that ongoing failure has been shown to lead to an increase in substance abuse and criminal activity, both of which are aspects of the homeless environment. Such factors can predispose homeless people to developing or exacerbating mental illness. The authors conducted a study with 61 shelter users in Maryland with the purpose of determining the incidence of poor self-esteem in this population. Using the Hudson Self-Esteem Index Scale, the researchers found that 54 percent of the subjects scored at a level indicating a problem with self-concept that required

therapeutic intervention. Other findings were that 75 percent of the sample were depressed, 72 percent had problems with family relationships, one-fourth had gone hungry at least one day of the current month, and one-half reported use of illegal drugs. The factors found to have a significant correlation to low self-esteem were depression, problems in family relationships, outlook on ability to achieve personal goals, status of health, and food deprivation. Those factors that did not have a significant influence on self-esteem were age, gender, race, marital status, religious beliefs, income level, substance abuse, length of time homeless, and psychiatric hospitalizations. Ironically many of these factors have been traditionally viewed as having a positive effect on a person's ability to achieve goals and in the prevention of homelessness. The results of this study illustrate the importance of a homeless person's belief in their ability to achieve goals. Recommendations were made for identifying individual causes of poor self-esteem when working with homeless persons and then designing solutions to address the causes identified.

The homeless mentally ill population has been found to differ from the general homeless population as well as the general mentally ill population. In their overview of research and services for the homeless mentally ill, Dennis, Buckner, Lipton, and Levine (1991) reported that compared to other homeless persons, homeless mentally ill persons have fewer supportive

relationships, a greater incidence of substance abuse, more barriers to employment, and were receiving fewer public benefits. Cohen, Onserud, and Monaco (1993) compared the mean scores of a psychiatric and non-psychiatric group of homeless individuals on the SHORT-CARE (Comprehensive Assessment and Referral Evaluation). The scores of the psychiatric homeless group reflected significantly greater deficits in the areas of physical health, activities of daily living, depression, and alcohol abuse. Bachrach, Santiago, and Berren (1990) examined social and financial differences between homeless and domiciled mentally ill individuals admitted to the emergency room of Kino Community Hospital in Tucson, Arizona. A greater percentage of the homeless mentally ill group lived alone and did not receive Supplemental Security Income or parental assistance.

Dixon, Krauss, Myers, and Lehman (1994) examined the housing preferences of homeless mentally ill persons who applied for Section Eight (government owned) housing through a community treatment team in Baltimore. Of the 77 applicants for Section Eight housing, 34 clients actually received certificates. Those who received the certificates were found to have less psychopathology and tended to have affective disorders versus schizophrenia. Of the 43 clients who did not receive certificates, 19 stated that they did not want one, 10 were evaluated by staff as being unable to live in an unsupervised setting, and the others either terminated the program

early or did not qualify financially for Section Eight housing. It should be noted that although the majority of clients who received certificates for housing were successful in their placements, the issues of loneliness and social isolation still existed for this population. Two female clients chose to give up their apartments because of these issues. Thus, addressing the needs for social support in the homeless mentally ill population must accompany interventions for independent living.

Factors Contributing to Homelessness Among the Mentally Ill

The policy thought to be the primary cause of homelessness among the mentally ill is a factor of the deinstitutionalization movement. As this policy as implemented between 1955 and 1981, the state and county mental hospital population decreased from 559,000 to 125,000 patients nationally (Dato & Rafferty, 1985). As patients were released into the community, the monies for support services did not follow. As a result, many patients decompensated to the point that they were unable to maintain stable housing patterns which led to homelessness. Belcher and Toomey (1988) examined the relationship between deinstitutionalization, psychiatric disability, and homelessness and reported that 35% of their sample of mentally ill persons released from a state hospital became homeless within three months. These results supported the theory that deinstitutionalization leads to homelessness for the mentally ill. Lamb (1988) supported this view in

stating "Probably nothing more graphically illustrates the problems of deinstitutionalization than the shameful and incredible phenomenon of the homeless mentally ill" (p. 941).

In contrast, Bachrach (1993) acknowledged several positive aspects of deinstitutionalization. She stated that this policy has led to "our heightened awareness of the humanity and the needs of mentally ill individuals" (p. 523). She goes on to apply the biopsychosocial model, which supports understanding the patient, his or her social context, and the existing system of treatment offered by society prior to implementing the treatment. It is pointed out that deinstitutionalization has actually served to reveal unique characteristics of the mentally ill that were not considered under the previous system of routine and prolonged hospitalizations. As a result of knowing these individual differences, more specialized treatment plans can be developed for mentally ill persons.

The homeless experience in general is recognized as a possible factor leading to an increase in the homeless mentally ill population. The reality of the negative effects that homelessness has on an individual's state of physical and mental health is pointed out by Begun (as cited in Martin, 1988) when he stated that "probably no one, however sane, could remain physically and emotionally intact after even a week in these conditions" (p. 135). Cohen and Thompson (1992) viewed the homeless mentally ill as suffering

from the stressors that all homeless persons face rather than their pathology. These authors point out that while deinstitutionalization was implemented during the 1960s and early 1970s, the drastic increase in the homeless mentally ill population did not occur until the late 1970s.

Thus they attribute political and socioeconomic changes such as decreased availability of low-income housing, the loss of manufacturing jobs, and cuts in social welfare programs as being the primary forces that led to homelessness among poor and marginal populations, including the mentally ill. In a study by Roth and Bean (1986) homeless mentally ill persons identified their social and economic problems as being the primary reasons leading to their homelessness.

McCabe, et al. (1993) examined the actual economic circumstances that persons receiving supplemental security income (SSI) were facing when attempting to acquire permanent housing. The Housing and Urban Development (HUD) guideline to affordable housing states that a person should spend no more than thirty percent of his or her gross income on housing expenses. It was estimated that SSI provides a person approximately twenty-four percent of the average income of persons in the general population. This breaks down to be an average of \$2.35 an hour, which is definitely below minimum wage. When the costs of renting an efficiency apartment or a one-bedroom apartment were obtained in various

counties nationwide, it was impossible to find any affordable housing, as defined by HUD, for persons receiving SSI. The results of the nationwide housing search show that it took 66% of a SSI check each month to rent an efficiency apartment and 80% to rent a one-bedroom apartment.

In addition to decreased availability of low-income housing, other factors that complicate the problem of caring for the chronically mentally ill in the community are opposition from neighborhood residents who are unsupportive of the development of programs in their neighborhoods and lack of supervised community residences (Bassuk & Lamb, 1986; Dennis, Buckner, Lipton, & Levine, 1991).

Assessment of Needs of the Homeless Mentally Ill

In attempting to evaluate specific needs of the homeless mentally ill population, self-report techniques have primarily been utilized (Morrissey & Levine, 1987). Freddolino, Moxley, & Fleishman (1988) assessed self-perceived daily needs of people with mental disabilities who were leaving residential treatment settings and entering the community. The areas of income and benefits, legal issues, housing, employment and vocational training, and health care were identified as needs by more than 25% of the participants. A similar study conducted by Moxley & Freddolino (1991) examined the self-perceived needs of homeless and domiciled people coping with mental illness. The homeless group identified a greater percentage of

with mental illness. The homeless group identified a greater percentage of needs, specifically in the areas of income and benefits, housing, legal issues, employment, and health care. Gelberg & Linn (1988) asked homeless individuals what they felt the three most important things that persons in their situation needed to improve the quality of their lives. The most frequently reported needs were improved social relations, employment, housing, and money, respectively.

Hogg and Marshall (1992) administered the MCR Needs for Care Assessment to 46 homeless mentally ill individuals who were long-term residents in two British hostels. The MCR Needs for Care Assessment is a standardized assessment of clinical and social domains and includes various activities of daily living in the social domain. The most common problems were found to be in the areas of occupation, socially embarrassing behavior, use of public amenities, managing own affairs, and the presence of positive psychotic symptoms. The problem status in the areas of shopping and cooking was often not known because the hostels provided these services. Similarly, the hostels provided money management services to ensure that the residents paid their bills and thus there were no reported needs in the area of money management. Although the results reflected the manner in which the hostels are run, the authors suggested that rehabilitative services in the areas of skills training and occupation are recommended for this

population. The importance of obtaining the client's interest in possible intervention was emphasized as a critical area that this assessment did not address.

The perspective of the homeless mentally ill person has been found to differ from that of health care professionals when attempting to determine service needs. In their review of recent research on the homeless mentally ill, Jones and Katz (1992) reported that basic needs are often a priority over clinical treatment for homeless mentally ill persons. Mulkern and Bradley (1986) surveyed homeless mentally ill people who sought services in Boston. Fifty-three percent of their sample requested clothing, 45% desired medical care, 45% wanted assistance obtaining food or food stamps, 34% requested help in applying for benefits, and 32% desired housing. Only 25% reported a need for psychiatric services and 3% requested emergency mental health care. Such differences in service priorities must be considered when developing programs for the homeless mentally ill in order to ensure effective utilization of services offered.

Although needs assessment based on self-report has been conducted with the homeless mentally ill population, few studies have attempted to assess actual performance skill levels in this population. Cognitive performance of homeless mentally ill veterans was assessed by Foulks, McCown, Duckworth, & Sutker (1990) through a series of neuropsychological

functioning of homeless mentally ill veterans and the general population.

These results implied the existence of adequate problem solving skills in the homeless mentally ill population that contributed to their ability to survive in the community. However, Louks and Smith (1988) reported that homeless patients who scored in the average intellectual range on the Shipley-Hartford IQ test had a mean conceptual quotient that reflected impairments in problem solving and abstract thinking. These deficits suggested that homeless persons are limited in their ability to function in the community. However, in both of these studies, cognitive performance was assessed primarily through formal psychological testing and not on actual task performance.

Thompson, Thornby, Boerings, and Lewis (1995) compared MMPI scores between 58 veteran psychiatric inpatients with stable housing and 54 without stable housing in order to identify psychosocial needs specific to those without stable housing. The group of patients without stable housing scored higher on the Social Alienation MMPI sub-scale, which indicated greater feelings of isolation. A significant difference was found between the marital status of the two subject groups. The study found that 34.5% of the patients with stable housing were married while only 3.7% of those without stable housing were married. Other notable differences found were that 34.5% of patients with stable housing were employed whereas only 16.7% of

34.5% of patients with stable housing were employed whereas only 16.7% of those without stable housing were employed. No differences were found in the areas of legal problems or substance abuse between the two groups. The authors recommended inpatient discharge planning that included vocational rehabilitation and development of social support systems for those patients without stable housing.

Surveys have been conducted with the homeless mentally ill population in efforts to determine their preferences for housing and community resources. Tanzman (1993) completed a review and summary of 26 such surveys that had been conducted throughout the United States and Canada between 1986 and 1992. Findings illustrated that the primary preference of homeless mentally ill individuals was to live in their own house or apartment. Secondary preferences were to live with family, in board-and-care facilities, or in group homes. Single room occupancy housing, hospitals, and being homeless were the least preferred options. In the majority of the studies surveyed, the respondents reported that they preferred to live alone. Secondary preferences were to live with a spouse or romantic partner or with family. Most respondents recognized the need to have support staff available for crisis intervention, assistance with money management and managing medication. However they preferred that staff be on call for utilization as needed instead of living in the same residence. Other needs reported by this

population were an increase in income and benefits, the need for telephones, transportation services, and assistance with developing social skills.

Intervention with the Homeless Mentally Ill

Intervention with the homeless mentally ill to this point has focused primarily on the provision of housing and case management services. These interventions have had a positive effect on the physical and mental well-being of this population and are foundational for future program development.

Housing stability has been found to have a positive effect on persons living with mental illness. The National Institute of Mental Health has funded housing programs designed to assist mentally ill persons living independently in the community. One such program based in Eugene, Oregon reported that their residents spent fewer days in the hospital while also demonstrating greater housing stability (Hildner & Block, 1990). Lipton, Nutt, and Sabatini (1988) reported similar findings in a longitudinal study conducted to compare the effects that residential treatment programs have on homelessness, hospital admissions, and client satisfaction. Homeless mentally ill inpatients were assigned to one of two groups upon discharge from an emergency psychiatric facility. The control group received procedural post discharge care while the experimental group was placed in a residential treatment program. After one year, 69% of the experimental group were

living in permanent housing, while 30% of the control group were living in permanent housing. The mean percentage of nights the subjects were homeless after discharge was 6% for the experimental subjects and 46% for the control subjects. The mean number of nights spent in a psychiatric hospital over the course of the year was 55 for the experimental group and 168 for the control group. In addition, the experimental group rated the quality of their living arrangement as adequate, while the control group rated the quality of their living arrangement as fair. These results support the development of residential treatment programs as a means of helping to improve the quality of life for homeless mentally ill persons.

Dixon, Friedman, and Lehman (1993) examined the effects that intense treatment provided at the community level had on the housing patterns of 33 homeless mentally ill individuals in Baltimore. The services provided included psychiatric and nursing care, case management, counseling, and family outreach. Transitional housing was also made available for the participants. Over a period of ten months, the majority of the patients receiving services from the treatment team moved from the streets into some type of housing. Transitional housing was utilized most frequently, followed by permanent housing, institutional shelter, then missions or the streets. In a different study utilizing the same population, Dixon, Friedman, and Lehman (1993) monitored the compliance levels of 26 homeless mentally ill

persons in the areas of finances, housing, daily structure, medical care, activities of daily living, and substance abuse. Individual treatment plans with specific goals in each of these areas were established by the primary case worker, working in collaboration with the patient. After three months the case worker rated the patient's level of compliance with various aspects of the treatment plan on a four point scale, with one indicating the most compliance. The mean ratings ranged from 1.85 for activities of daily living to 2.96 for daily structure. The findings suggest that overall the patients were compliant with the treatment program except in the area of daily structure. Other significant findings were positive correlations between compliance in the area of substance abuse and compliance in the areas of housing, medical care, and daily structure. These results indicated that substance abuse in this population is a central factor that influences other areas of treatment and thus must be directly addressed in order to provide appropriate intervention. Poor compliance in daily structure was associated with poor housing outcomes, indicating that patients who did not engage in activities during the day were less likely to maintain a stable housing situation. It was determined that this area of need must be addressed if long-term housing placement for the homeless mentally ill is to be successful.

Rife, First, Greenlee, Miller, and Feichter (1991) conducted a study to assess the effects that case management had on the quality of life for 46

homeless mentally ill persons in the Midwest. The Quality of Life Interview was administered to the client initially and then after six months of receiving case management services. Clients reported improvement in their quality of life in the areas of living situation, global well-being, finances, safety, and health. No significant improvement was reported in the areas of unemployment, family relations, and religion. Overall, this study showed that case management can be instrumental in securing housing placement for homeless mentally ill persons. However, the individuals in this study continued to face challenges to establish successful employment and social support systems. Wasylenki, Goering, Lemire, Lindsey, and Lancee (1993) conducted a study to examine the effects of case management on the level of functioning of 59 homeless mentally ill persons in Toronto over a nine month period. Significant improvement was noted in the areas of housing stability and social functioning.

Decreased psychopathology was evidenced as well as increased size of the client social networks. However, it was pointed out that these social networks were still smaller than those of domiciled chronically mentally ill persons. Factors thought to predispose this population to social isolation are reflected in the subject demographic data. Nearly all (99%) of the sample was not married and 76% was not employed.

Stoner (1989) reported outcomes of money management services provided within the framework of case management for homeless mentally ill persons in the Skid Row area of Los Angeles. The Skid Row Mental Health Service worked in conjunction with the Social Security Administration to offer substitute payee services for homeless mentally ill persons utilizing a drop-in day shelter. Eighty-nine clients enrolled in the program and were monitored for one year. The staff consisted of social workers, community workers, and public guardian personnel. Working as a team, they used persuasion, limit setting, and made recommendations to encourage clients to use their money for basic needs. By the end of the study, 82% of the clients were living within their allocated income and 77% of the clients reported that they were no longer homeless but had stable housing situations. The number of clients who were poorly groomed decreased from 92% to 53% and the number of clients who reported being robbed or arrested decreased from more than one-half initially to only 9% after one year in the program. The level of perceived client cooperation increased from 19% at the beginning to 80% one year later. In addition, 75% of clients in the money management program were utilizing the county's mental health system for the first time. These results illustrate the effectiveness of providing training in a community living skill such as money management to the homeless mentally ill population. This program was the first of its type in Los Angeles County and

Los Angeles County and only the second nationally. It serves as a model and foundation for future intervention.

Other recommendations for training in community living skills for the homeless mentally ill are made by Taylor and Warren (1993). In providing guidelines for psychiatric nurses working with this population, the authors emphasize the importance of discharge planning from inpatient psychiatric hospitalization. Teaching patients skills such as basic first aid, medication management, and utilizing community resources prior to discharge was encouraged. Suggestions were made to provide the patient with supplies necessary for self-care and community skills such as soap, toilet paper, deodorant, first aid kit, bus token, map, address book, and medical alert bracelet. In addition, the need for developing networks between inpatient and community health care workers in order to monitor and facilitate transitions with these patients was stressed. It was also suggested that incorporating cultural activities such as music and stories into treatment with the homeless mentally ill is a possible method to foster trust and increased compliance with this population.

Some of these recommendations have been implemented and found to be beneficial for the well-being of individuals who are homeless and mentally ill. For example, Silver and McKinnon (1994) reported the benefits of an extended inpatient program for homeless psychiatric patients in New York.

The program was designed to provide placement in permanent housing upon discharge and encouraged medical management of mental illness. The factors found to contribute to discharge potential were the willingness of the patient to comply with their medication regimen, avoidance of substance abuse, and the acceptance of discharge placement in the community. Over a two year period of time, it was found that 66.7% of the patients treated in the extended inpatient program accepted community discharge placements while 27.1% of those discharged from a nearby acute psychiatric hospital agreed to such a placement. The average length of stay in the extended care program was 113.9 days. The authors concluded that the difference in these placement rates indicated that an extended inpatient stay may allow certain patients to prepare better for transitioning into permanent housing.

Acknowledging that homelessness leads to isolation and loneliness and that music facilitates socialization and offers pleasure and entertainment, a music program was developed for clients who attend a day shelter operated by the University of Kentucky School of Nursing (Peden, 1993). The goals of the program were to increase socialization among the clients, provide entertainment, and provide a chance for the clients to relax. In selecting the music for the program, the individual interests of the clients were considered. Local musicians were solicited and asked to volunteer their time and talents to the program. In addition to live music performances, sessions utilizing

recorded music were also held. When playing recorded music, the psychiatric nurse who was leading the session would stop the music at various points and allow clients to express any thoughts or feelings that the music was eliciting. As a result, discussions about various concerns of the clients, including the need for friendships took place. It was noted that in times of crisis clients were more likely to approach those nurses who had led the music group. Thus, music was found to be a method of building therapeutic relationships with clients at this shelter. The music group led to an overall increase in the quality of life for the clients, evidenced by verbalizations of enjoyment that the music brought them, improvement in their affect, initiation of contact with the staff, and increased socialization with other clients who were involved in the group.

Murray and Baier (1993) described the application of therapeutic milieu to a transitional residential facility for homeless mentally ill persons in St. Louis. Upon admission to this facility, the staff and clients identified various needs of the clients and developed specific goals to be met during the client's stay at the facility. In reporting their needs to staff, 99.1% identified housing as a need, 65.4% reported that they needed ongoing treatment for their mental illness, 57.5% wanted to learn interpersonal skills, 54.4% wanted to find supportive counseling, 53.9% stated they wanted to obtain employment, and 45.6% desired to obtain other benefits. Other needs

reported were being able to manage their medication, learn to structure their free time, control substance abuse, learn money management skills, improve personal hygiene, acquire health care, receive supervision with activities of daily living, receive education or training, live in a structured setting, and learn relaxation methods. Residents participated in community life within the facility, such as carrying out specific responsibilities assigned to them, contributing to group decisions, and participating in activities at the facility. In addition, clients were involved in activities outside the facility, such as day treatment programs, vocational rehabilitation, church activities, and substance abuse support groups. In the five and one-half year history of the facility, 48.8% of the clients achieved their goals and were placed in permanent housing.

Berman, Barilich, Rosenheck, and Koerber (1993) described a homeless center created by the Veteran's Administration (VA) Medical Center in response to the recession and increase in the homelessness in the Dallas-Fort Worth area in the mid-1980s. The mission of the center was to assist homeless veterans in getting off the streets and returning to productive living. The center set up partnerships with various organizations in the community to provide services to implement this mission. One such partnership was with an agency that trained the veterans to work in building maintenance. Other work programs offered veterans wages but also required

that they receive treatment for their substance abuse problems. The VA worked collaboratively with the Social Security Administration and the state of Texas to ensure efficient processing of applications for Supplemental Security Income and Social Security Disability Insurance. The VA also joined with the United States Department of Housing and Urban Development to provide vouchers for Section Eight housing for veterans who completed a residential treatment program. This comprehensive homeless center developed by the Dallas VA Medical Center is unique in its design of incorporating a variety of sectors that offer a continuum of treatment for the homeless mentally ill veteran.

The compliance of homeless mentally ill persons with assertive community treatment in the Baltimore area was evaluated by Dixon, Friedman, and Lehman (1993). Compliance was defined as "the extent to which the patient carried out tasks defined in the treatment plan" (p. 581). Individual treatment plans were developed by a case manager in collaboration with the patient when the patient entered the program. The treatment plans consisted of several categories, including finances, daily structure, housing, activities of daily living, medical care, and substance abuse. Goals in these areas were set in a graded manner, according to the status of the patient. Ratings of compliance in these areas were made after the patient was in the program for three months. A four point scale was used,

with one indicating that the patient was generally compliant and four indicating that the patient was generally noncompliant. Mean scores ranged from 1.85 for activities of daily living to 2.96 for daily structure. Correlations were found between compliance in the area of substance abuse and compliance in the areas of housing, daily structure, and medical care. Similarly, compliance in the area of daily structure was found to be correlated to compliance in the area of housing. Patients with schizophrenia were found to be less compliant than those with other diagnoses in the area of activities of daily living. The average rating of the six areas was 2.15, indicating that the patients were generally compliant but had some areas of noncompliance. It was noted that the area of daily structure, which involves the patient finding activities to occupy their time during the day, needs to be addressed with this population because of the relationship it has with compliance in the area of housing.

Acknowledging that the physical and psychological problems of homeless people are different from the general public helps establish the need for unique evaluation and treatment approaches for this population. Although the results of deinstitutionalization are still being felt today, understanding its relationship to homelessness among the mentally ill is useful in developing strategies to counteract its negative results. Understanding the social and economic stressors that all homeless people

face is also helpful when considering interventions with this population.

Viewing permanent housing and aggressive case management as positive factors in increasing the quality of life for homeless mentally ill persons supports residential program development for this population. Yet, examining the actual needs of this group on primarily a self-report basis does not provide a specific performance profile in which to fully develop such programs. Thus, the need to adequately assess actual skill performance levels in the homeless mentally ill population while acknowledging individual perceptions from this population supports the purpose of the current study.

Summary

This literature review identified the frame of reference that guided the present research, provided information on the homeless and homeless mentally ill populations, discussed possible factors contributing to homelessness among the mentally ill, and examined evaluation and intervention with the homeless mentally ill population. This body of information served as a foundation to understanding the homeless mentally ill population and to direct the current study.

CHAPTER 3

DESIGN AND METHODOLOGY

Purpose

The purpose of this study was to determine specific problem areas in the homeless mentally ill population based on performance and self-report in order to develop appropriate treatment programs for this unique population.

Study Design

This is a non-experimental research study employing the analytical survey method and the descriptive survey method. The main variables in this study are age and gender. These variables were not controlled in the homeless mentally ill sample. Attempts were made to roughly match age and gender of the "normal" subject group with the homeless mentally ill group. However, this was a difficult task because of the unpredictable nature of the selection process for the "normal" sample. Therefore, the variables of age and gender were accepted as partially controlled.

Research Questions

The research questions were:

1. Is there a difference in the performance of community living skills between homeless mentally ill and the normal population?
2. What are the overall performance assets and liabilities of homeless mentally ill persons?

3. What do homeless mentally ill persons identify as their greatest needs?
4. How do homeless mentally ill persons describe the effects of homelessness on their physical and mental health?

Subjects

Thirty subjects participated in this study. Fifteen subjects each comprised the homeless mentally ill group and the "normal" group. The subjects in the homeless mentally ill group were residents at the Spring Street Shelter in Redwood City, California. Prior to initiating contact with these residents, written approval of the research project was obtained from the shelter director (see Appendix A) and submitted to the Institutional Review Board as part of the request to use human subjects in research. This request was subsequently approved by the Institutional Review Board (see Appendix B). The homeless mentally ill subjects were then approached by the agency program director or shelter case manager and asked if they were interested in participating in the study. Those interested were scheduled for an appointment with Carolyn Glogoski, the principal investigator of the study.

The normal subject group consisted of fifteen persons who were not homeless and who had no previous history of mental illness. These subjects were recruited through an ad placed in the Spartan Daily newspaper at San

Jose State University and also through personal references from the research assistants who were Rachel Brady and Dave Rose.

Methodology, Procedures, and Instruments

All subjects were seen for two individual sessions. At the beginning of the first session, the subjects read, signed, and received a copy of a consent form which explained their participation in the study as well as their rights as subjects (see Appendix C). Following completion of the consent forms, the Mini-Mental State Examination (MMSE) (Folstein, Folstein, & McHugh, 1975) was administered to all subjects by the principal investigator. This instrument was used as a screening tool to ensure the client's ability to speak, read, write and understand English, follow directions and sustain attention. A MMSE score of 22 or better was required to indicate the subject's ability to provide informed consent. During the second session, the Scorable Self-Care Evaluation (SSCE) (Clark & Peters, 1984) (see Appendix D) was administered to all subjects by the research assistants. Prior to using the SSCE, written consent to reproduce the SSCE manual was obtained from the publisher, Slack Incorporated (see Appendix E). The SSCE is a standardized evaluation of self-care tasks and has a standardized procedure for using sub-tasks to specifically address basic community living skills. This instrument evaluates levels of independence in the areas of personal care, housekeeping, financial management, work, and leisure. After administration of the SSCE,

administration of the SSCE, a semi structured interview (see Appendix F) consisting of eight open-ended questions was conducted with the homeless mentally ill subject group only. The subjects were asked to sign a form giving consent to audiotape the interview. During the interview, subjects were asked to identify needs for services that might enhance their functioning in the community. Subjects were also asked to describe how being homeless has affected their physical and mental health. The interview was designed by this researcher and conducted by this researcher and a fellow research assistant. All subjects were offered a small monetary compensation for their participation in the study. The homeless mentally ill subjects each received two dollars at the end of the first session and two dollars at the end of the second session. The "normal" subjects received one dollar at the end of the second session.

Data Analysis Techniques

Several techniques were employed in reporting the data collected in this study. A between subjects matched samples t-test was used to compare the performances of the two subject groups on the SSCE. T-tests were used to examine both the SSCE total scores as well as scores on each individual part of the SSCE. These quantitative results were used to address research questions one and two.

Interview results were first transcribed from the audiotapes and then summarized case by case in narrative form. Portions of the interview content were then used to answer research questions three and four. Research question three was addressed through the calculation of simple percentages based on various responses given during the interviews. In addressing research question four, portions of the interview manuscript were coded according to themes observed. The type of coding used is defined by Bogdan and Biklen (1982) as situational coding, which aims at grouping data in a manner that reflects the world view of the subject in relation to the topic. The themes identified are referred to as domains. Each domain is discussed individually, incorporating quotations from the actual interviews.

CHAPTER 4

DATA AND RESULTS

The data are presented in the following manner:

Demographic information describing the two subject groups is reported, followed by case summaries of the interviews conducted with the homeless mentally ill subjects. The research questions are then restated and answered. Questions one and two are answered using quantitative data from the Scorable Self-Care Evaluation (Clark & Peters, 1984). Questions three and four are answered using qualitative data from the semi-structured interviews with the homeless mentally ill subject group.

The homeless mentally ill group consisted of ten men and five women ranging in age from 35 to 57 years, with a mean age of 42 years. All were residents of the Spring Street Shelter in Redwood City, California. Ten of the subjects had been homeless from one to six months and five of the subjects had been homeless for one year or longer. All subjects met the diagnostic criterion of having a major mental disorder. Eight of the subjects had a diagnosed major mood disorder, five of the subjects had been diagnosed with schizophrenia, and two of the subjects had delusional disorders. Ten of the subjects also had problems with substance abuse. The "normal" subject group was comprised of five men and ten women ranging in age from 24 to 60 years, with a mean age of 34 years. Nine (60%) of these subjects were college

students. These subjects had no history of mental illness and had never been homeless.

Case Data

Case One: Wendy is a 33 year-old single African American female. She has a history of a delusional disorder and has been without permanent housing for less than six months. When asked to describe survival when living on the streets she replied "keep myself clean, making sure that I am in contact with people who care about other people, and pray." She stated that "money" was her greatest need at this time, as well as "housing and some further schooling." She stated that she would like to learn how to make more money, be able to find housing and be financially independent. She was agreeable to the idea of attending classes at the shelter if they were available. She thought the shelter could "set up workshops where they could actually teach people how to function more independently and more productively, and offer skills programs for people that are on disability," adding that she thought that some people on disability were intelligent and skilled with the potential to function well. Wendy stated that she wanted to live somewhere other than on the street and if she could choose where to live she explained that it would be:

In a private room by myself where I could like think and pray like I wanted to and maybe cry off some of the pain of being on the street and talk to some people in private like reverends and people that are truly concerned about me.

When discussing community living skills, Wendy thought that it was important to have "the ability to think for yourself in a way that makes sense," giving the examples of accepting the restrictions of living on a budget and the need to seek out advice from a therapist. She added that "There are people out there that cannot become functional by themselves. They need somebody to help them do that." She went on to define a "functional" person as someone who is looking for employment, making efforts to be placed in temporary housing in order to save money, and taking "steps to be independent." When asked what the effects of being homeless were on her physical and mental health, Wendy pointed out that physically she was getting plenty of exercise because she was not sitting around her apartment as much. She discussed the mental effects of homeless to a greater degree, stating that "mentally it puts pressure on you and it scares you. It scares me because you don't want to end up like this for the rest of your life or most of your life or until you get so old that most corporations wouldn't hire you." She explained that this "age factor" was motivating her to go back to school and update her skills to meet her goal of earning a degree in business.

Case Two: Stan is a 38 year-old single white male. He has a history of a delusional disorder and has been without permanent housing for less than six months. When asked to describe important strategies for surviving on the street, Stan explained that a person must have a safe place to sleep, a

sleeping bag, and a way to make some money "so you can get inside, even if it's just for a cup of coffee or something." He added that he lived in his car for an extended period of time when he was working full-time. He reported that "steady employment" is his greatest need at this time. He is interested in learning job skills and training that would lead to the ability to support himself. He was aware of the Regional Occupational Program (ROP) and described it as "a program that has on the job training and job training classes that you could take while you're working or looking for work." He thought that the shelter could offer assistance with job recruitment and agreed that he would attend classes on this topic if they were offered at the shelter. Stan desires to get off the streets permanently and states that he would like to live in an apartment. He was somewhat doubtful about this desire being realistic as he commented "realistically where I've been living for the last five years is in hotels, you know, when I don't live on the streets." When asked what community living skills were important to maintaining permanent housing Stan stated, "Well, just not to make trouble. I don't drink to excess or use drugs or break the law." When asked to describe how being homeless has affected his physical and mental health, Stan replied:

Well, I'll tell you, it hasn't been too good. It wears you down. You get a kind of exhaustion from it I think. For me, physically I feel about the same but my outlook now isn't too positive. It's been going on for so long for me, since 1986.

Case Three: Jason is a 40 year-old divorced white male. He has a history of mood disorder and has been without permanent housing for more than twelve months. When asked to describe strategies of surviving when out on the street, Jason replied that he would apply for general assistance and food stamps and try to locate a suitable shelter in which to reside. He stated that if no shelters were available he would try to find a safe place to sleep at night. When asked how he determined what was safe he explained that this information was obtained through word of mouth, prior experiences, and by the section of town the shelter was located. He commented, "If there are a lot of crack addicts in the shelter, I would rather sleep in a field somewhere because they tend to be violent, steal, and things like that." He reported his greatest needs to be "to go to work, save money, and get a place of my own." He stated that he would like to learn self-discipline in the area of money management, commenting that "I know how to budget money on paper but when it comes right down to it sometimes I get irresponsible and spend more than I know I should and end up out of luck." He also said that he would like to take some classes in the areas of accounting in order to learn a job that would not be stressful on his body. He recognized that his hip and knee joints were wearing out and that he needed employment other than hard manual labor. He was in favor of attending classes if offered at the shelter. He suggested that it would be helpful to have a representative from the Regional

Occupational Program (ROP) come and give classes at the shelter or have the shelter assist with transportation to ROP classes in the community. Jason stated that he wants to get off the streets permanently and ideally would like to live in a house. He prefers a duplex or one bedroom house where he would have privacy but said he would also be able to manage in a hotel room that was quiet and affordable. When prioritizing community living skills Jason thought that the most important skill is being able to "sustain employment" and then being able to budget in order to save money. In discussing how being homeless has affected his physical and mental health he mentions both the physical strain it has caused as well as depression and an altered outlook on life:

I have hip and knee joint degeneration and I'm sure it's affected my legs. You have to do a lot of walking around when you're homeless. If you're not working you have to spend your time doing something, and so I spend a lot of time walking and so that wears me out and causes me pain. As for my mental health, it has caused me depression and when I'm in a depressed state of mind, I get into "survival mode" is what I call it, which keeps me looking kinda at real small things like just "What can I do?", "How can I get a cigarette?" or "What can I get for my next meal?" rather than any kind of long term goals, which would be better for me. It keeps me homeless. The homelessness is a state of mind that causes me to stay that way.

Jason explained that in order to get out of this state of mind it helps him to be in a drug and alcohol program in which he can stay clean and sober for a period of time. He states that his thinking starts to clear up when he is clean and sober and that working over a period of time also helps his thinking to

become more positive. When asked if working helped suppress his substance abuse Jason stated that it did:

When I'm working, on the one hand I have money, but I'm also taking up my time during the day with things and I'm tired and I tend not to want to use that. Whereas if I just have a little bit of money and I'm not working, I get kind of hopeless and say "Well, I might as well just get drunk or something and just try to forget where I'm at." It just seems futile to try to save five bucks. I mean, for what, you know? That's not going to do anything to change my situation, so I tend to spend it on alcohol.

Case Four: Peter is a 36 year-old divorced white male. He has a history of mood disorder and has been without permanent housing for three months. He has lived on the street and stated that clothing and food are important items for street survival. He reported his greatest needs at this time are to have his knees examined and to find a place to live. When asked what skills he would like to learn in order to survive better Peter mentioned being able to attend dual diagnosis groups and "anything to be around people because I'm pretty much of a loner." He said he would attend support groups at the shelter if they were offered. He had no suggestions for other programs at the shelter. He stated that he does want live somewhere other than the streets and verbalized the desire to live in Campbell, California because he plans to return to work in that area. When asked what type of housing he specifically desired, he stated "a house." The community living skills that he reported as most important were "dressing appropriately, keep your apartment or house clean, and try to be friendly." When asked to describe how homelessness had

affected his physical and mental health, Peter replied "I'm healthy. It hasn't really affected me at all." He went on to explain that there were schools and other facilities that served food daily and that "the only thing you're lacking is a roof over your head."

Case Five: Ralph is a 54 year-old single white male with a history of mood disorder. He has been without permanent housing for more than twelve months. Ralph has lived on the streets of San Mateo County and was very knowledgeable about the various resources available for survival. He stated, "First off, you got to get the basics." He went on to say that it is helpful to make contact with experienced street people and ask them questions on resources for food, clothing, and shelter. He listed several facilities in San Mateo County, such as the American House, where clothing is available and lodging is available to families. He also mentioned St. Vincent's of Paul, where sack lunches are available. For showering he suggested going to the Martin Luther King Center, which is open six days a week for free showers. For clothing, he suggested going to the Samaritan House and he knew the days that it is open.

When asked what was his greatest need at this time Ralph stated, "To get my money caught up with me." He explained that while he was hospitalized for eight months his Social Security was terminated, reportedly due to a computer error. He was waiting to receive retroactive funds and

planned to deposit the money into a fund for his long term care. When asked what skills he would like to learn in order to survive better he responded, "I'd like to learn my money management and get off the streets. I'm not a street person, really." He went on to distinguish himself from those street people that "love living on the streets" and are "a little neurotic." He furthermore explained that the closure of the mental hospitals by Ronald Reagan in 1971 is what lead to an increase in homelessness. When redirected to the topic of financial management and asked if he would attend classes if offered at the shelter, Ralph replied, "No, I wouldn't because I knew financial management. I know everything about it ... I don't give a damn is what I mean. I know how to manage. I just want to learn how to get control of myself again." When asked about what he thought the shelter could offer, Ralph responded by explaining that the shelter was offering him a place to stay while he was waiting for his money to come in and that he enjoyed socializing with some of the shelter staff. He also responded by describing what he was doing for others at the shelter, stating "I'll help the less fortunate people ... I've been offered many times in the VA to become a counselor." When asked where he would like to live if able to get off the streets he stated "a room in a private home with kitchen privileges." In describing important community living skills Ralph mentioned tasks such as "maintaining your apartment, paying your bills on time ... keeping a well stocked larder and living clean if you

have problems with drugs or alcohol." He added that "motivating yourself and getting back your self-esteem" was also important and that this required going out into the community. He suggested activities such as attending concerts in the park and going to the library.

When asked to describe the effects of homelessness on his physical and mental health, Ralph explained that it led to hospitalization for alcoholism and Bipolar Disorder. He told of a time that he had become so depressed that he was borderline suicidal and thus admitted himself into the hospital. He also reported that as a homeless person he had been hassled by the police in Central Park when he would go there to watch softball games. He went on to explain the routines he went through in order to care for his personal hygiene, such as showering and doing laundry. He stated that keeping clean decreases the likelihood of being hassled by the police. Ralph also recommended staying in good physical shape, staying off drugs and alcohol, and finding a warm safe place to sleep in order to "make it out there." He went on to explain that he once had some clothes stolen when he was staying at a shelter so he chose to live in a trash room where cardboard boxes were dumped. When describing the area he called it "a little penthouse" that offered him privacy and stated that he does not give out the address:

You have your own place and you don't give your address out. Just like you have your own house and if you want to give out your telephone number or your address, you only give it to certain people. It's the

same way on the streets. You don't give out your little penthouse, your little hideaway. That's all yours. That's your territory.

Case Six: Laura is a 39 year-old single white female with a history of schizophrenia. She has been without permanent housing for less than six months. However, Laura has never lived out on the streets. She was residing at the shelter temporarily while she looked for a permanent residence. She states her greatest need was "to have a permanent place to stay." She thought that receiving counseling at the shelter would assist her in functioning better and she stated that she would attend counseling sessions if they were available at the shelter. When asked what type of counseling she was interested in she clarified that it was counseling to help her get a job. Laura stated the desire to live in her own apartment and that meal planning, personal self-care and being able to balance a checkbook were important skills necessary for maintaining a permanent residence. When asked how being in housing transition had affected her physical and mental health, Laura explained that she had only been at the shelter for a few days and that she was still adjusting to it. She stated that it was "very stressful" following the required schedule of waking up early and being out of the rooms until the evening. She added that it was also "kind of tiring."

Case Seven: Martha is a 45 year-old single white female. She has a history of schizophrenia and has been without permanent housing for less than six months. She has never lived on the streets but came to the shelter as a result

of her house going into foreclosure. When asked what her greatest need was she mentioned several things including socialization with people, contact with her therapist, maintaining a positive attitude, keeping herself clean and physically fit, and going to work. The things that she wanted to learn in order to get along better were primarily emotional and spiritual in nature. She stated she desired "to regain in my own personal faith in God and my own beliefs of who I am and just keep going on a positive mental attitude on a day to day basis." She thought the shelter might offer help in obtaining this positive mental attitude and well as offer help in the "day to day struggles" of someone experiencing depression and loss. She went on to explain the various losses she had suffered, including the emotional and physical abuse of her father, the loss of her home, and the "loss of the love" of her teenage daughter. She summarizes these losses:

So it's a three-fold loss. It's a tremendous economic loss, it's a tremendous emotional loss, and it's a heartbreaker in trying to establish my own individuality as a woman and as an achiever.

Martha hoped to return to the home she had been living in prior to coming to the shelter. She stated that the factor that is most important to living independently in permanent housing was having a good support group. With this she says, "You can get through anything." She explained that it was important to initiate and maintain contact with the support group on a regular basis. Martha reported that her son and her therapist offered her the

strongest support. She also tells of the importance of not feeling sorry for oneself, stating, "If you start feeling sorry for yourself then you're defeating yourself ... then you're going into depression, which leads to suicide thoughts." When asked how losing her home had affected her physical and mental health, Martha stated that she had encountered physical struggles as a result of not being able to afford daily requirements and medication to maintain health. She reported that she just had to go without them.

Case Eight: Edith is a 56 year-old widowed white female. She has a history of having had a stroke and has been without permanent housing for three weeks. Prior to coming to the shelter she lived in a second floor apartment. She stated that her social worker had placed her in the shelter because her doctor was afraid she would fall down the stairs and "break her hip." From the shelter she stated that she planned to live in a retirement home in Burlingame. When asked what she would like to learn in order to function better, she stated, "Well, to understand people when they're sick" and then went on to explain how one woman at the shelter talks to a wall and another laughs and talks to herself. Edith stated that she does not understand their behavior "because I've never been in this predicament." As a result she would like to have more understanding of "people with more severe problems than I have." When asked what she thought the shelter could offer she stated, "Better planned meals." The community living skills that she thought

were most important to independent living were cooking, budgeting money, doing washing and ironing, and paying rent. Edith reported that one benefit of coming to the shelter was the opportunity to save some money. She stated that "I have about \$350 saved of my own money."

Case Nine: Lisa is a 57 year-old single Asian female. She has a history of mood disorder and has been without permanent housing for less than six months. She has never lived on the street. When asked about the type of housing in which she was living prior to coming to the shelter, she replied:

I was living in the apartment and then we had to leave the apartment. We had so much trouble living in the apartment and so we got pushed out, my son and I. We lived in a motel for awhile and then my son got sick. He needs to be hospitalized and taken care of. That was a stress emotionally.

Lisa stated that from the shelter she planned to find another apartment to rent or go to a "board and care" home. When asked what her greatest need is at this time, she reported, "Going back to work...to have money to pay for rent, to get food, apartment." The things she wanted to learn in order to function better were developing her social skills, specifically in the area of verbal communication. She agreed that she would attend classes at the shelter to learn these skills if they were available. Another suggestion that Lisa had was that the shelter might offer more activities for the residents. She stated that she enjoyed bowling, tennis, swimming, and going on outings such as attending arts and crafts shows. The skills she listed as being

important to independent living were cooking, washing clothes, cleaning, talking with people, typing or making jewelry in order to work at home.

When asked how being in transition has affected her physical and mental health Lisa stated, "Well, I'm not too comfortable. It's a strain." She went on to mention that residing at the shelter was "alright...socially it's alright" but that "there's nothing to do." When asked how she felt about initially coming to the shelter she explained, "It was a strain. Coming here...I felt stupid. I felt uncomfortable. It's a lot of stress. But not because of the people...I've read about shelters."

Case Ten: Stacy is a 48 year-old divorced white female. She has a history of mood disorder and has been without permanent housing for less than six months. She reported that she has never lived on the streets but came to the shelter because she previously lived in the Mojave desert and could not find work there. Initially she went to her daughter's home in the Bay Area without telling her daughter that she was coming. She explained:

My family is up here and I decided to just come and I didn't want them to tell me "no", so I didn't call anybody. So I just showed up on my daughter's doorstep. I was kind of impulsive, but I knew I needed to be up here and not down there...This is home and I have some support with my family.

The day after showing up at her daughter's, her children put her up in a hotel for a week and encouraged her to get back on her medication, which Stacy says keeps her "relaxed." From the hotel, she came to the shelter. When

describing what it was like coming to the shelter she stated, "It was scary coming here. I was kinda angry with my kids. A lot of times you don't know what it's like. I was afraid. I've never been in this situation before." After accommodating to life at the shelter she explained, "I found out that there's a lot of support and a lot of people and it's not dangerous. People are afraid of places like this because you don't know." She went on to tell of her initial concerns for safety. "What I have is just mild depression, so it's scary because you're afraid people are going to hurt you." In spite of her initial hesitations, Stacy was able to verbalize positive aspects of coming to the shelter. "I made new friends that I wouldn't have made had I not been here." When asked of her plans for future housing she reported that she had signed up for some housing in Caminar and was also looking for a studio apartment that her son would help her with financially. She commented that she had been working on staying on the medication "like he wants" her to be on.

She stated that her greatest need was a full-time job, explaining that she was currently working part-time and that was not enough. She stated that she would like to learn "more patience" because she wants "everything to happen real fast." When asked what she thought the shelter could offer she replied, "I think that people who come in here are really really sick and they need some counseling. Not me specifically, but I've seen people that are, you know." She went on to suggest that having counseling available when people

first come to the shelter would make the transition easier and less frightening. She also thought it would be helpful to formulate a plan for each resident's situation. For those who have difficulty functioning she suggested the availability of workshops that would offer a structured program as helpful. She explained:

I mean there's people that can do it on their own but then there's people here that really need help. You know the lady who like I had to tell them that she couldn't take care of herself, you know, taking a shower and stuff like that...You have to bring it to their attention. It seems to me they don't see things fast enough. They don't have anybody that can really do that. Maybe they don't have the funds, I don't know.

She continued on about this need and described another resident who was "real slow," had difficulty managing her money, and had no support from her family. She stated, "Nobody's taken the time to find out that she's slow and that she does need help to do these things."

Stacy stated that she would like to live permanently in a studio apartment or in a residence where she could share the cost with someone. The community living skills that she listed as being important to maintaining permanent housing were "being able to budget your money, a good job, having some social contacts." When asked how being in a housing transition has affected her physical and mental health, she stated:

Well, I think it's made me a lot more content. I think it's been good for me, very good for me because I see how I am. It's given me a lot more compassion that I don't think I had before. I mean I've had it and it's coming out now.

In addition, Stacy commented that the things that were difficult about living at the shelter were that people come into the rooms and steal and that she had never experienced that before. She stated that she has become "shelter wise" and she was not before. She also stated that "dorm life in general was a little bit hard to get used to because we didn't have our privacy."

Case Eleven: Doug is a 34 year-old single white male. He has a history of schizophrenia and has been without permanent housing for less than six months. He stated that he has lived on the streets and that work, clothing, and food are the things that are important for survival on the streets. To get these things he said he goes out and looks for work and when he is not working he is on the streets "because it just costs too much." He reported his greatest need to be permanent housing. When asked what he would like to learn in order to get along better he replied:

I'd like to learn how to budget my money more, how to watch it more so that I don't give it away and, um, learning how to exercise (utilize) my income basically so that I can get food or whatever...um, getting my life to work.

He agreed that he would attend classes if offered at the shelter in order to learn these skills. When asked what else he thought the shelter could offer he said "assistance with my everyday life" in the areas of "eating, keeping my clothes clean, and staying well washed." Doug desires to live in a house if he was able to get off the street permanently. He reported that paying rent and

having the responsibility of running a household in an "orderly fashion", including preparing meals are all important community living skills necessary to sustain permanent housing.

When asked to describe how being homeless has affected his physical and mental health he explains:

I don't know. It kinda wears at you. You get tired of doing it. It's a struggle. And sometimes you feel like right now it'd be easier to get out and start over...to get off the streets and go to a board and care home, you know.

When asked to describe how this struggle felt he replied, "Just the everyday thing, you know, every hour."

Case Twelve: Wes is a 47 year-old divorced African American male. He has a history of a mood disorder and has been without permanent housing for more than twelve months. He reports that he has lived on the streets and stated that to "eat properly...get three meals a day if possible, take care of your body...shower and stuff" are important skills for survival on the streets. To accomplish these tasks, he reported that he goes to churches that provide meals and goes to the YMCA to take showers. He adds that when he is living in shelters, meals are provided there and also at "Saint Anthony's on Tuesdays." He reported his greatest need at this time to be "a job" and stated that he would like to learn "how to manage money" in order to get along better. He said he would attend a class if offered at the shelter to learn money management. He had no additional ideas of what the shelter might

offer. Wes stated that he does want to get off the streets and that he would like to live in San Diego in residential housing because he wants to live somewhere where he can have his children visit. He felt that important community living skills necessary to maintain permanent housing are "a job, to be able to paint the house, to take care of the house, cook, wash, and iron."

When asked how being homeless has affected his physical and mental health he stated, "Well it hasn't affected me physically but it's affected me mentally, you know. I stay depressed all the time. I'm not used to that." He claims that he did not have problems with depression prior to becoming homeless. When asked how he copes with his depression he explained, "It's not easy...just pray, just pray."

Case Thirteen: Jim is a 33 year-old divorced African American male. He has a history of a mood disorder and has been without permanent housing for more than twelve months. He stated that he has lived on the streets. When asked what he does to survive out on the streets he replied:

I do a lot of panhandling, usually in the Berkeley area, that's where I'm from, where it's legal. I eat my meals from restaurants and buy food from stores, but mostly restaurants. And uh...some of the things I do to help me survive are try to stay away from trouble, and not to break any laws. And that's basically all I have to do to stay [away] from problems when living on the street.

When asked what he did to "stay out of trouble" he replied that he avoided getting into arguments and tried to stay away from street drugs and alcohol. He admitted that he has problems with drugs and alcohol and that he is

currently attending twelve step meetings. Jim reported "housing" as his greatest need. He added that another need is getting into a drug and alcohol program called Project 90. He planned to start that program the following month and explained that he will be staying at the shelter until that time. After completing the Project 90 program he said he will be placed into transitional housing. When asked what he would like to learn in order to survive better he replied, "I'd like to learn how to manage my money." He was in favor of attending classes if offered at the shelter in order to learn money management. When asked what else he thought the shelter could offer he went on to explain the frustration he was feeling over the shelter's policy of not issuing bus tickets to persons who have a source of income. He stated that although he has an income he runs out of funds toward the end of the month and it is at that time he comes to the shelter. He felt that he should be able to receive bus tickets from the shelter when he is in such a situation in order to attend his appointments with his doctor, case manager, and AA meetings.

Jim would like to live in a shared housing program where he would have roommates to share the cost of rent, food, and bills. The community living skills that he thinks are important to living in permanent housing are being able to "do your assigned tasks each day in the household...plan meals with the right ingredients to have a balanced meal, and be responsible enough

with money management to be able to pay your part." When asked to describe how being homeless has affected his physical and mental health he replied:

It's affected my mental health a lot. Now I hear voices and see things most of the time and I didn't used to. I'm more suicidal now and I didn't used to be suicidal...I was just manic-depressive. Physically I have arthritis which has taken over in my back and some of my limbs. I'm only 33, you know, and I already have that. I was beaten up by a baseball bat on my left leg by some guys who robbed me in another city when I was homeless.

He stated that he did not have arthritis at all before he was on the street and that his mental health has gotten progressively worse.

Case Fourteen: Ron is a 52 year-old married African American male. He has a history of schizophrenia and has been without permanent housing for less than six months. He reported that he lived on the streets for one day and to survive he stated, "You have to learn how to take care of yourself." When asked how he does this he responded "by panhandling, killing, robbing, whatever you do." After being on the streets, Ron went to a rooming house and before coming to the shelter he was in a drug center. From the shelter he hopes to go back to his family. He defined his greatest need as being "able to handle my own money." In order to get along better he stated that he would like to go back to school and get his GED. He had no suggestions for possible programs at the shelter. When asked what community living skills were important to living in permanent housing, he said, "Well, just washing cars

and yardwork. Window washing and stuff like that. That's domestic work."

When asked how being homeless has affected his physical and mental health he stated, "Well, it hasn't affected me in any kind of way. It's a pretty good feel here." When asked to clarify how he was prior to coming to the shelter he replied, "I was on drugs and all of that, you know, pulling me down."

Case Fifteen: Joe is a 42 year-old divorced white male. He has a history of a mood disorder and has been without permanent housing for less than six months. He stated that he lived on the streets for about nine months. When asked what he thought was important to survival out on the streets he answered:

Keep eating...always make sure you've got something to eat and don't let yourself get hungry. I like to keep myself clean. It's a real depressing situation to be in, you know. If you just stay full of food and maybe be around friends or whatever...and of course the weather plays a part of it too.

When asked how he went about doing these activities to survive he admitted, "I got into crime, to tell you the truth, to get money. It's as simple as that."

When asked to tell of his greatest need he stated, "I as going to say a million dollars, but that's not true. Probably friends." In order to get along better Joe expressed a desire to "get a handle" on his substance abuse problem and "get reeducated as far as that's concerned." He also expressed a desire to "get a new lease on life." When asked to define what this meant he said, "I'd like to get a different perspective and like walk out of here or

wherever I'm going to be as another person so I don't have to fall back to my opiate use." He was willing to learn some of these things through programs if offered at the shelter and added that he was attempting to get into the Project 90 program in San Mateo. He described this program as "a substance abuse living facility where I guess it strongly leans on the twelve step program." He could not think of other services that the shelter could offer besides the basics of "a roof, a shower, a chance to wash clothes, and of course food."

Joe stated that he would like to "once again own my own place, as I did in the past. A condominium or a house or whatever." Community living skills that he thought were important for achieving permanent housing were being able to read a newspaper, understand traffic lights, understand English, understand how to shop for food and pay bills. When asked to describe how being homeless had affected his physical and mental health Joe replied, "I've lost a little bit of weight and I probably don't feel as good about myself as I did in years past. Um, but other than that...It's kind of embarrassing, a little bit embarrassing."

Results

Research Question One: Is there a difference in the performance of community living skills between homeless mentally ill and the normal population? Highly significant differences ($p < .001$) between the two subject

groups were found in the SSCE total scores as well as in scores on the sub-scales of personal care and work and leisure. A significant difference ($p < .05$) between the two subject groups was found in the sub-scale scores for financial management. No significant difference was found between the two subject groups in the sub-scale scores for housekeeping (see Table 1).

Research Question Two: What are overall performance assets and liabilities of homeless mentally ill persons? The assets reflected in the SSCE scores for the homeless mentally ill sample are in the area of housekeeping. This is the only sub-scale in which no significant differences were found between the performance of the homeless mentally ill sample and the normal sample. Similarly, the finding of highly significant differences between SSCE scores of the homeless mentally ill sample and the normal sample in the sub-scales of personal care and work and leisure suggests that these areas may be serious liabilities for the homeless mentally ill sample. In addition, the finding of a significant difference between SSCE scores for the two subject groups in the sub-scale of financial management suggests that this area also may be a liability for the homeless mentally ill sample.

Research Question Three: What do homeless mentally ill persons identify as their greatest needs? When asked the question "What is your greatest need at this time?", the 15 subjects gave a total of 24 responses. Eleven of the subjects gave one response, one gave two responses, two gave

Table 1

Differences Between Mean SSCE Scores: Homeless Mentally Ill Versus Non-Homeless Non-Mentally Ill Groups (N = 30)

	Group 1: Homeless Mentally Ill	Group 2: Non-Homeless Non-Mentally Ill	t-test
Scorable Self-Care			
Evaluation	(N = 15)	(N = 15)	(df = 28)
Total Score	36.13	23.87	3.86**
Personal Care	17.27	11.67	4.34**
Housekeeping	10.20	8.67	1.17
Work/Leisure	1.73	.33	4.30**
Financial Management	6.20	3.20	2.44*

Note. Lower scores indicate greater independence.

* $p < .05$. ** $p < .001$.

three responses, and one gave five responses. Of the 24 responses given, six (25%) expressed the need for housing, six (25%) expressed the need for employment, and five (21%) expressed the need for money. Two responses given (8%) stated the need for "friends, people, or company." Responses reported one time each (4%) were the need for physical examination, money management, psychological services, a "positive attitude," and "keeping clean and healthy" (see Table 2).

In response to the question "What are some things that you might like to learn to help you survive better?" the 15 subjects gave a total of 19 answers. Twelve of the subjects gave one response and three gave two responses. Of 19 responses given, six (32%) expressed the desire to learn money management skills, three (16%) expressed the desire for drug/alcohol support groups, two (11%) expressed the desire to receive job skills training, two (11%) desired social support, and two (11%) desired counseling or emotional support. Responses each mentioned one time (5%) included assistance finding housing, education on mental illness, learning patience, and returning to school to get a GED (see Table 3).

Eleven subjects were asked the subsequent question "If you could learn this through the shelter would you attend a class or program?" Ten (91%) indicated that they would. When asked specifically "What do you think the shelter could offer?", 10 subjects gave a total of 12 suggestions. Five subjects

Table 2

Homeless Mentally Ill Subjects' Self-Report of Their Greatest Needs (N=15)

Need Reported	Percent of Subjects Reporting this need
Housing	25
Employment	25
Money	21
Social contacts	8
Physical examination	4
Money management skills	4
Psychological services	4
Positive attitude	4
Good hygiene and health	4

Table 3

Skills Homeless Mentally Ill Subjects Reported They Would Like to Learn (N=15)

Skill	Percent of Subjects Who Reported Desire to Learn This Skill
Money management	32
Drug/alcohol support groups	16
Job skills training	11
Social support	11
Counseling/emotional support	11
Assistance with finding housing	5
Education on mental illness	5
"Patience"	5
Education to receive GED	5

stated that they did not have any suggestions. Of the 12 suggestions given, four (33%) related to job training, counseling, recruitment, or placement. Three (25%) of the responses suggested providing assistance or education in activities of daily living, specifically in the areas of eating, personal hygiene, and money management. Two (17%) of the responses suggested providing counseling, emotional support, or assistance with coping. Responses given one time each (8%) included providing better planned meals, more activities (such as bowling, tennis, swimming, outings), and free bus tickets to travel to appointments in the community (see Table 4).

Research Question Four: "How do homeless mentally ill persons describe the effects of homelessness on their physical and mental health?" Fourteen of the subjects were asked the question "How has being homeless (in housing transition) affected your physical and mental health?" Seven primary domains were identified from their responses. These domains are: Essentials, Negative Behaviors, Roles and Routines, Social and Spiritual Aspects, Psychological Aspects, Physical Aspects, and Perspective.

Essentials

Essentials are defined as concrete tangible items that are needed to achieve and maintain independent living. More specifically, this domain includes income, money management skills, housing, employment, education, food, clothing, and activities of daily living. Seven (50%) of the subjects

Table 4

Suggestions Homeless Mentally Ill Subjects had on Possible Shelter Programs (N = 10)

Suggestion	Percentage of Subjects Offering This Suggestions
Job training, counseling, placement	33
Assistance/training in activities of daily living	25
Counseling/emotional support	17
"Better planned meals"	8
More avocatoinal activities	8
Provision of bus ticket	8

interviewed mentioned at least one of these aspects of life when describing how being homeless had affected them. Subject One reported her concerns about being able to return to work and the need to return to school in order to have adequate skills that would allow her to become employed again. Subject Two described how being unemployed has kept him focused on basic needs, such as obtaining food. He explained that when he is not working it seems "futile to try and save five bucks." Subject Four did not feel that being homeless had significantly affected him, commenting that "the only thing you're lacking is a roof over your head." He also listed several facilities that he knew of where a homeless person could obtain food. Subject Five seemed to be experienced at street living and explained that he showered, had money and clean clothes, and enjoyed going to the park to watch the softball games. He also told of how he had found his own shelter in a trash room he referred to as his "little penthouse." Subject Seven reported that not having adequate finances prevented her from obtaining daily requirements of nutrients and medicine. She stated, "For a long time I simply didn't have them."

Negative Behaviors

Substance abuse and criminal activity will be referred to as negative behaviors. Five (36%) of the subjects interviewed mentioned such activities when describing how homelessness had affected them. Subject Three explained that his problem with alcohol abuse is exacerbated when combined

with the stressors of being unemployed. The feelings of hopelessness led him to say, "I might as well just get drunk or something and just try to forget where I'm at." The hopelessness he felt when trying to save small amounts of money also led him to spend it on alcohol instead. Subject Five stated, "If you don't drink or drug, you can make it out there." He also mentioned several times how he was hassled by the police, adding that he had filed a suit against the city of San Mateo because two police officers had harassed him. During another part of the interview he reported how he had bags of clothing stolen while staying at a homeless shelter, adding "that's two in four years." Subject Ten also reported that theft was occurring at the shelter where she was currently residing. Subject Thirteen described how he had been assaulted when on the streets, stating, "I was beaten up [with] a baseball bat on my left leg by some guys who robbed me in another city when I was homeless."

Roles and Routines

This domain addresses the element of time and the importance of personal space and privacy. In responding to the question on how being homeless has affected them, eleven (79%) of the subjects mentioned some aspect of this domain. Subject One commented that being homeless allowed her to get more exercise because she was not "sitting around" in her apartment as much. Subject Two explained how he has struggled with being

homeless since 1986, stating, "It's been going on for so long for me." This time element has been a factor in his struggle to maintain a positive outlook. Similarly, Subject Eleven spoke of the constant struggle he has experienced, describing it as "just the everyday thing, you know, every hour."

Subject Three reported that he spends much of his time walking. He explained, "If you're not working you have to spend your time doing something, and so I spend a lot of time walking and so that wears me out and causes me pain." He went on to tell about his need to be clean and sober "for a number of months" in order to change his perspective. He also described the need to work and "be successful for a period of time" in order for his thinking to become more positive. He explained that working is therapeutic to addressing his problem with substance abuse, stating, "When I'm working, on the one hand I have money, but I'm also taking up my time during the day with things and I'm tired and I tend not to want to use that." Subject Four reported the routines he utilizes in order to obtain food, stating, "There's schools that serve food five days a week and there's other places in San Mateo. There's a place right here in Redwood City that you can get food if you need it." Subject Five also described some of the routines he has when living on the streets. He reported how he spends time in conversation with other alcoholics, goes to the park to watch softball games, goes to the YMCA to take showers, and goes to the laundromat to wash his clothes. He explained in

detail his procedures for ensuring that he kept himself clean, such as using separate bags for his clean and dirty clothing. When talking of how being homeless affected him physically, he told of the importance of finding warm shelter and how he had found "a little place" in a trash room where crushed boxes were dumped. He referred to it as his "little penthouse" and stated that no one gets the address. He declared, "You don't give out your little penthouse, your little hideaway. That's all yours. That's your territory. That's the rule(s) of the road."

When telling of the effects of being in housing transition, Subject Six mentioned that adhering to the shelter's schedule of being up at seven in the morning and not being able to return until the late afternoon was stressful for her. Subject Nine also commented on shelter life, stating that "It's OK, but there's nothing to do." Subject Ten explained that shelter life was difficult to adjust to because "we didn't have our privacy."

Social and Spiritual Aspects

The social and spiritual domain includes the support that individuals need and find with friends, family, and spiritual beliefs and practices. In speaking of how their homeless situations have affected them, four (29%) of the subjects referred to some aspect of this domain. Subject Five told of the conversations he has on a regular basis with other people in his situation. He also mentioned that he had one particular "buddy" with whom he talked

when living on the streets. Subject Nine felt that she had found some social support at the shelter, as did Subject Ten. Subject Ten also told of the initial plans she formulated of living with her daughter in the Bay Area without consulting her. After coming to the shelter, she realized that she had been impulsive and needed to "work on working things out and not just depending on people like that" but in the next sentence stated, "My kids have been good to me." When telling of how he coped with the depression he experienced since becoming homeless, Subject Twelve explained, "It's not easy. Just pray, just pray."

Psychological Aspects

The psychological effects of homelessness and the need for management of mental illness through medication, hospitalization, and/or counseling are the aspects covered in this domain. In their discussions on the effects of homelessness, eleven (79%) of the subjects interviewed included some aspect of this domain. Subject One stated that "mentally it puts pressure on you and it scares you." Similarly, Subject Two explained, "It hasn't been too good. It wears you down and you get a kind of exhaustion from it. Mentally it's beginning to wear me down. It's changed my outlook. My outlook isn't too good." Subject Three reported that being homeless has caused him depression, which prevents him from setting long term goals. Subject Five also reported that being homeless caused him to become

depressed and "borderline suicidal." As a result, he admitted himself into an inpatient psychiatric hospital and spent two months in a locked ward before being transferred to a open ward.

When describing her experience of being in housing transition, Subject Six stated, "It's very stressful." Subject Nine had a related experience, explaining "I'm not too comfortable. It's a strain. It was a strain coming here. I felt stupid. I felt uncomfortable. It's a lot of stress." Subject Eleven also commented on the exhaustion that being homeless had caused him, stating "It kinda wears at you. You get tired of doing it. It's a struggle." Subject Twelve reported that he now stays depressed most of the time and that he did not experience depression prior to becoming homeless. Similarly, Subject Thirteen explained that he has had exacerbation of his mental illness since becoming homeless. He stated, "It's affected my mental health a lot. Now I hear voices and see things most of the time and I didn't used to. I'm more suicidal now and I didn't used to be suicidal, I was just manic-depressive."

Physical Aspects

The domain of physical aspects includes any response that subjects gave about how being homeless affected their physical health or well-being. In their responses to how being homeless had affected them, eight (57%) of the subjects mentioned this domain. Subject One told of the concern she had about aging to the point that she would not be employable. Subject Two

stated that physically he felt "just as good" as before he was homeless. On the contrary, Subject Three reported that he now had "hip and knee joint degeneration" as a result of the walking related to being homeless. Subject Five also told of physical problems, including an episode of cellulitis that developed into a staphylococcal infection for which he had to be hospitalized. Subject Six reported physical exhaustion resulting from being homeless and Subject Seven reported the physical struggle she experienced as a result of not having the finances to purchase medication and nutrients. Subject Thirteen told of how at the current age of 33 he had arthritis in his back and extremities. He also reported being physically assaulted when he was homeless. Subject Fifteen mentioned that he has lost some weight as a result of being homeless.

Perspective

This domain is broad and includes outlook on life, goal setting, view of self, self-esteem, motivation, and attitudes. All of the subjects interviewed included some aspect of this domain when describing how being homeless had affected them. Subject One realized that she was growing older and had not achieved her career goals. She was able to state the goals of returning to school to earn a degree in business and then find employment. Subject Two reported an outlook that was not positive but realized that it was not a permanent outlook and felt there was some hope for his future. Subject Three

described how he gets into a "survival mode" when he is depressed, which keeps him looking only at short term needs rather than long term goals. He stated that this thinking keeps him homeless, explaining, "The homelessness is a state of mind that causes me to stay that way." He also reported how his outlook becomes hopeless when he is not working and how the hopelessness leads him to use alcohol to try and cope. It seems pointless to him to try to save money when he is in this situation because he cannot see a way out. Subject Four had a somewhat indifferent outlook on his homeless situation, claiming that "I'm healthy. It hasn't really affected me at all." Subject Five saw himself as "a clean street person" and described the trash room where he lived as "not garbage or anything."

Subject Six had only been out of permanent housing for a short time and was therefore still adjusting to her situation. Due to the financial limitations that being homeless placed on her, Subject Seven told of how she had to fulfill her needs on her own the best she could. Subject Nine explained how she was uncomfortable coming to the shelter at first because of what she had read about shelters. She stated she "felt stupid" about having to come to the shelter. Similarly, Subject Ten described how her initial entrance to the shelter was difficult because she did not know who else was there. She stated that now she has become "shelter wise" and not so trusting of others. Subject Eleven reported how he sometimes feels that "right now it'd be easier to get

out and start over," referring to his desire to get off the streets and find other housing. When describing the psychological effects of being homeless, Subject Twelve claimed that he was not used to being depressed. Similarly, when speaking of the arthritis he developed while being homeless, Subject Thirteen stated, "I'm only 33, you know, and I already have that." Subject Fourteen claimed that since coming to the shelter he had not been affected by being homeless, stating, "It's a pretty good feel here." Subject Fifteen acknowledged that he did not "feel as good" about himself as he has in the past and that being homeless has also caused him to feel embarrassed.

CHAPTER 5

SUMMARY, IMPLICATIONS, RECOMMENDATIONS

This study was designed to determine specific performance problem areas in a homeless mentally ill sample based on performance and self-report. Knowledge of these problem areas is considered to be foundational for further research and for describing practice implications for occupational therapists. This study constitutes the first research conducted to assess task performance of homeless mentally ill persons in community living skills through the use of a standardized evaluation tool. While the results are not generalizable to the entire homeless mentally ill population due to the small sample size and the fact that participants were residing in a shelter, there are some important findings to be considered.

Summary

Objective assessment of community living skills with a homeless mentally ill sample was achieved in this study through the administration of the Scorable Self-Care Evaluation (Clark & Peters, 1984). The objective results of this study show that significant differences exist in the functional levels of this homeless mentally ill sample and a normal sample in several areas of community living skills. The homeless mentally ill subject group performed poorly in the areas of personal care, work and leisure, and financial management. In addition, the self-reported qualitative findings

identified needs of the homeless mentally ill subject group which reinforced these objective findings. The self-reported needs for ensuring physical health and hygiene parallels the components found in the SSCE sub-scale for personal care. Similarly, the reported needs for housing, employment, income, and social support correlate with the SSCE sub-scale of work and leisure. Finally, the reported need for money management skills reflects a component addressed in the SSCE sub-scale of financial management.

The SSCE scores for the sub-scales of personal care, work and leisure, and financial management suggest that these tasks could be considered overall liabilities of the homeless mentally ill sample. The tasks involved in these sub-scales include orientation, hygiene and appearance, locating phone numbers from a telephone book, identifying first aid procedures, identifying leisure activities and participation, reading a map, identifying skills needed to use public transportation, explaining current employment status and plans, making change, writing out a sample check, identifying information on a sample utility bill, writing out a budget, and answering questions on supplemental income and source of current income. Viewing these tasks as liabilities for the homeless mentally ill provides direction for intervention with this population and may assist in treatment planning geared toward improvement in these areas of deficit.

While the study was designed to determine specific performance problem areas in a sample of homeless mentally ill persons, the SSCE scores for the sub-scale of housekeeping suggest that the homeless mentally ill sample is able to successfully perform the tasks involved in this sub-scale. Thus, these areas could be considered performance assets for this sample.

The SSCE sub-scale of housekeeping is comprised of four categories: foods selection, house chores, safety, and laundry. The foods selection category involves planning balanced meals for two days. The house chores category involves sequencing the activities that a person usually performs after eating a meal, such as washing dishes and sweeping the floor. The safety category involves identifying safety hazards in six different pictures that are presented to the subject. The laundry category involves listing items a person needs to take to the laundromat in order to do laundry, answering basic questions on tasks necessary to perform prior to doing laundry, and then sequencing the steps involved in performing the activity of doing laundry. Although the SSCE scores suggest that the homeless mentally ill sample may be able to perform these activities just as well as the normal sample, it is relevant to point out that approximately half of the normal subjects were college students. A generalization made of college students is that housework is not a priority for them because of the demands of their

coursework. Thus, the performance of college students on the housekeeping sub scale may not be an accurate representation of the normal sample.

Implications for Occupational Therapy

The findings of this study have implications for the areas of practice, advocacy, education, and research for the field of occupational therapy. In the area of practice it is recommended that occupational therapists consider more involvement in the treatment of the homeless mentally ill both in hospital and community settings. The performance deficits in the areas of personal care, work and leisure, and financial management noted in this study suggest that these are potential areas for intervention by occupational therapists. Results of this study can provide a beginning place for therapists to work with this population and direct treatment planning. Such a specific treatment focus in an inpatient setting could result in more effective preparation of the homeless mentally ill patient for discharge from a clinical setting and for effective community living. In the community setting, homeless mentally ill persons could benefit from functional evaluation and training by occupational therapists for ongoing development of community living skills. Such evaluation and training could take place in shelters and transitional living facilities. Therapists might also be able to follow a person through the transition from shelter to transitional living and provide training necessary for successful living in the environment where they are placed. In

the shelter setting occupational therapists could provide useful resources for shelter staff who work with homeless mentally ill persons and could provide inservice education on issues related to this population.

Application of occupational therapy theory was expanded to include a population not frequently addressed in the occupational therapy literature. The Model of Human Occupation subsystems of volition, habituation, and performance are reflected in the results this study. The subsystem of volition, which refers to the internal motivation that one uses to explore the environment can be detected in the domain entitled "Perspective." In examining this domain, it is evident that the internal motivation, ability to set goals, and the discipline to meet goals is affected by the homeless situation itself. When coupled with a major mental illness, a person's ability to function in this subsystem may be significantly impaired. The subsystem of habituation, which comprising the maintenance of a daily routine through the use of habits and roles is illustrated in the "Roles and Routines" domain. Operating in the role of "survivor," this population has been required to adopt unique routines to confront everyday situations. The element of time is significant and is viewed by some as a negative factor working against them and by others as a void that needs to be filled with activity. The performance subsystem, which involves skills required for successful community living, is reflected in the results of the SSCE.

In the area of advocacy, the discipline of occupational therapy could offer insights into the service needs of the homeless mentally ill based on objective functional assessment. With knowledge of specific service needs, policy makers would be enabled to direct limited funds more appropriately. In view of the tremendous shortage of low income housing for people who receive supplemental income (McCabe, Edgar, Mancuso, King, Ross, & Emery, 1993) the discipline of occupational therapy could join advocacy efforts to address this crucial need.

Recommendations

In view of both the objective and subjective findings in this study, the following recommendations are made. Because the scope of needs identified by the homeless mentally ill sample encompasses several disciplines, an interdisciplinary approach to research and intervention with this population is recommended. The involvement of physicians to address physical health needs, psychologists and psychiatrists to address mental health needs and problems with substance abuse, and social workers to assist with needs for acquisition of housing and supplemental income benefits is recommended. Traditionally these disciplines have had a role in treatment of the homeless mentally ill. In addition to continuing services provided by these professionals, it is recommended that the discipline of occupational therapy

become more involved with intervention for the homeless mentally ill population.

In the areas of occupational therapy education, homeless shelters and transitional living facilities are possible settings for occupational therapy students to complete practicum and internship experiences in the area of psychosocial practice. For this to take place, university programs in occupational therapy must consider these as viable possibilities, possible sites in their communities must be contacted, and collaboration with the homeless facility initiated to create a successful practicum experience.

Further research is recommended that utilizes a larger sample of homeless mentally ill persons and those outside a shelter setting. Since performance on a structured self-care evaluation such as the SSCE is only one possible indicator of an individual's actual performance skills, it is recommended that actual performance of homeless mentally ill persons in community living skills be assessed. It is also recommended that occupational therapists initiate research to study the effects of occupational therapy intervention.

REFERENCES

American Psychiatric Association. (1987). Diagnostic and statistical manual of mental disorders (3rd ed.- revised). Washington, DC: Author.

Bachrach, L. L. (1993). The biopsychosocial legacy of deinstitutionalization. Hospital and Community Psychiatry, 44, 523-524.

Bachrach, L. L., Santiago, J. M., & Berren, M. R. (1990). Homeless mentally ill patients in the community: Results of a general hospital emergency room study. Community Mental Health Journal, 26, 415-423.

Barris, R., Kielhofner, G., & Watts, J. H. (1988). Occupational therapy in psychosocial practice. Thorofare, New Jersey: SLACK.

Bassuk, E. L., & Lamb, H. R. (1986). Homelessness and the implementation of deinstitutionalization. In E. L. Bassuk (Ed.), The mental health needs of homeless persons (pp.7-14). San Francisco: Jossey-Bass.

Belcher, J., & Toomey, B. G. (1988). Relationship between the deinstitutionalization model, psychiatric disability, and homelessness. Health and Social Work, 13, 145-153.

Berman, S., Barilich, J. E., Rosenheck, R., & Koerber, G. (1993). The VA's first comprehensive homeless center: A catalyst for public and private partnerships. Hospital and Community Psychiatry, 44, 1183-1184.

Bogdan, R. C. & Biklen, S. K. (1982). Qualitative research for education: An introduction to theory and methods. Boston: Allyn and Bacon.

Clark, E. H., & Peters, M. (1984). Scorable self-care manual. Thorofare, New Jersey: SLACK.

Cohen, C., Onserud, H., & Monaco, C. (1993). Outcomes for the mentally ill in a program for older homeless persons. Hospital and Community Psychiatry, 44, 650-656.

Cohen, C. I., & Thompson, K. S. (1992). Homeless mentally ill or mentally ill homeless? American Journal of Psychiatry, 149, 816-823.

Dato, C., & Rafferty, M. (1985). The homeless mentally ill. International Nursing Review, 32, 170-173.

Dennis, D. L., Buckner, J. C., Lipton, F. R., & Levine, I. S. (1991). A decade of research and services for homeless mentally ill persons. American Psychologist, 46, 1129-1138.

Diblasio, F. A. & Belcher, J. R. (1993). Social work outreach to homeless people and the need to address issues of self-esteem. Health and Social Work, 18, 281-287.

Dixon, L., Friedman, N., & Lehman, A. (1993). Compliance of homeless mentally ill persons with assertive community treatment. Hospital and Community Psychiatry, 44, 581-583.

Dixon, L., Friedman, N., & Lehman, A. (1993). Housing patterns of homeless mentally ill persons receiving assertive treatment services. Hospital and Community Psychiatry, 44, 286-288.

Dixon, L., Krauss, N., Myers, P., & Lehman, A. (1994). Clinical and treatment correlates of access to section 8 certificates for homeless mentally ill persons. Hospital and Community Psychiatry, 45, 1196-1200.

Elias, C. J., & Inui, T. S. (1993). When a house is not a home: Exploring the meaning of shelter among chronically homeless older men. The Gerontologist, 33, 396-402.

Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). "Mini-Mental State": A practical method for grading the cognitive state of patients for the clinician. Journal of Psychiatric Research, 12, 189-198.

Foulks, E. F., McCown, W. G., Duckworth, M., & Sutker, P. B. (1990). Neuropsychological testing of homeless mentally ill veterans. Hospital and Community Psychiatry, 41, 672-674.

Freddolino, P. P., Moxley, D. P., & Fleishman, J. A. (1988). Daily living needs at time of discharge: Implications for advocacy. Psychosocial Rehabilitation Journal, 11(4), 33-46.

Gelberg, L., Linn, L. S., Usatine, R. P., & Smith, M. H. (1990). Health, homelessness, and poverty: A study of clinic users. Archives of Internal Medicine, 150, 2325-2330.

Gelberg, L., Stein, J. A., & Neumann, C. G. (1995). Determinants of undernutrition among homeless adults. Public Health Reports, 110, 448-454.

Harris, S. N., Mowbray, C. T., & Solarz, A. (1994). Physical health, mental health, and substance abuse problems of shelter users. Health and Social Work, 19, 37-45.

Hildner, C., & Block, L. (1990). Homeless mentally ill in the nineties. Journal of the Florida Medical Association, 77, 742-744.

Hogg, L. I., & Marshall, M. (1992). Can we measure need in the homeless mentally ill? Using the MRC needs for care assessment in hostels for the homeless. Psychological Medicine, 22, 1027-1034.

Hopkins, H. L., & Smith, H. D. (Eds.). (1988). Willard and Spackman's occupational therapy. Philadelphia: J.B. Lippincott.

Jones, B. E., & Katz, N. D. (1992). Evaluating recent research on the homeless mentally ill. Psychiatric Quarterly, 63, 41-50.

Lamb, H. R. (1988). Deinstitutionalization at the crossroads. Hospital and Community Psychiatry, 39, 941-945.

Lamb, H. R. (1990). Will we save the homeless mentally ill? American Journal of Psychiatry, 147, 649-651.

Levine, I. S., & Rog, D. J. (1990). Mental health services for homeless mentally ill persons: Federal initiatives and current service trends. American Psychologist, 45, 963-968.

Lipton, F. R., Nutt, S., & Sabatini, A. (1988). Housing the homeless mentally ill: A longitudinal study of a treatment approach. Hospital and Community Psychiatry, 39, 40-45.

Louks, J., & Smith, J. (1988). Homeless: Axis I disorders. Hospital and Community Psychiatry, 39, 670-671.

Martin, M. A. (1988). Homelessness among chronically mentally ill women. In L. L. Bachrach & C. C. Nadelson (Eds.), Treating chronically mentally ill women (pp. 127-140). Washington DC: American Psychological Association.

McCabe, S., Edgar, E. R., Mancuso, L. L., King, D., Ross, E. C., & Emery, B. D. (1993). A national study of housing affordability for recipients of supplemental security income. Hospital and Community Psychiatry, 44, 494-495.

Morrissey, J. P., & Dennis, D. L. (1986). NIMH-funded research concerning homeless mentally ill persons: Implications for policy and practice. Rockville, MD: National Institute of Mental Health.

Morrissey, J. P., & Levine, I. S. (1987). Researchers discuss latest findings, examine needs of homeless mentally ill persons. Hospital and Community Psychiatry, 38, 811-812.

Moxley, K. P., & Freddolino, P. P. (1991). Needs of homeless people coping with psychiatric problems: Findings from an innovative advocacy project. Health and Social Work, 16, 19-26.

Mulkern, V., & Bradley, V. J. (1986). Service utilization and service preferences of homeless persons. Psychosocial Rehabilitation Journal, 10, 23-29.

Murray, R. B., & Baier, M. (1993). Use of therapeutic milieu in a community setting. Journal of Psychosocial Nursing, 31(10), 11-16.

Neubauer, R. (1993). Housing preferences of homeless men and women in a shelter population. Hospital and Community Psychiatry, 44, 492-494.

Oakley, F., Kielhofner, G., & Barris, R. (1985). An occupational therapy approach to assessing psychiatric patients' adaptive functioning. The American Journal of Occupational Therapy, 39, 147-152.

Peden, A. R. (1993). Music: Making the connection with persons who are homeless. Journal of Psychosocial Nursing, 31(7), 17-20.

Rife, J. C., First, R. J., Greenlee, R. W., Miller, L. D., & Feichter, M. A. (1991). Case Management with homeless mentally ill people. Health and Social Work, 16, 58-67.

Ritchey, F. J., La Gory, M., Fitzpatrick, K. M., & Mullis, J. (1990). A comparison of homeless, community-wide, and selected distressed samples on

the CES-Depression Scale. American Journal of Public Health, 80, 1384-1386.

Roth, D., & Bean, G. J., Jr. (1986). New perspectives on homelessness: Findings from a statewide epidemiological study. Hospital and Community Psychiatry, 37, 712-719.

Schutt, R. K., Meschede, T., & Rierdan, J. (1994). Distress, suicidal thoughts, and social support among homeless adults. Journal of Health and Social Behavior, 35, 134-142.

Silver, M. A., & McKinnon, K. (1994). Finding alternatives to the streets for the homeless mentally ill: Efficacy at a state hospital intensive placement unit. Journal of Psycholinguistic Research, 23, 67-73.

Stephens, D., Dennis, E., Toomer, M., & Holloway, J. (1991). The diversity of case management needs for the care of homeless persons. Public Health Reports, 106, 15-18.

Stoner, M. R. (1989). Money management services for the homeless mentally ill. Hospital and Community Psychiatry, 40, 751-753.

Tanzman, B. (1993). An overview of surveys of mental health consumers' preferences for housing and support services. Hospital and Community Psychiatry, 44, 450-455.

Taylor, C. S., & Warren, B. J. (1993). What goals and interventions are important for psychiatric nurses to use when working with homeless chronically mentally ill? Journal of Psychosocial Nursing, 31(4), 35-39.

Thompson, J. P., Thornby, J., Boerings, J. A., & Lewis, F. (1995). Some selected psychological and social characteristics of veteran psychiatric inpatients without stable housing. Psychological Reports, 76, 391-394.

Wasylenki, D. A., Goering, P. N., Lemire, D., Lindsey, S., & Lancee, W. (1993). The hostel outreach program: Assertive case management for homeless mentally ill persons. Hospital and Community Psychiatry, 44, 848-853.

APPENDIX A
LETTER TO INSTITUTIONAL REVIEW BOARD

Mental Health Association of San Mateo County

2686 Spring Street, Redwood City, California 94063 • (415) 368-3345

January 3, 1991

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Institutional Review Board
Human Subjects Committee
Graduate Studies Office
Administration Bldg. Rm. 150
San Jose State University
One Washington Square
San Jose, CA 95192

Dear Committee Members:

The Mental Health Association of San Mateo County has received a request from Carolyn Glogoski to conduct a Research Project at the Association's Spring Street Shelter for the homeless mentally ill. Ms. Glogoski has indicated that she would be working with two graduate students and would assess the accuracy of the homeless mentally ill client's perceptions of their level of independence in community living skills using questionnaires and other assessment tools. It is our understanding that shelter clients would be volunteers in the study, the results of their participation in the study would be confidential and would in no way affect their eligibility to receive shelter services. We have received a copy of the research proposal, bill of rights and informed consent and wish to convey approval of this research project at our facility.

Sincerely yours,

Evelyn Stanton
Executive Director

APPENDIX B
INSTITUTIONAL REVIEW BOARD APPROVAL LETTER

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San Jose, California 95192-0025 • 408/924-2480

To: Carolyn Glogoski
Dept. of Occupational Therapy
San Jose State University

From: Serena W. Stanford *Serena W. Stanford*
AAVP, Graduate Studies and Research

Date: February 17, 1992

The Human Subjects-Institutional Review Board has approved your request to use human subjects in the study entitled:

"Self-Reported and Actual Performance in Community
Living Skills of Homeless Persons who are Mentally
Ill"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have questions, please contact me at 408-924-2480.

APPENDIX C
CONSENT FORMS

A campus of The California State University

School of Applied Arts and Sciences • Department of Occupational Therapy
One Washington Square • San Jose, California 95192-0059 • 408/924-3070 924-3070

CONSENT FORM

TITLE: SELF-REPORT OF COMMUNITY LIVING SKILLS

INVESTIGATOR: Carolyn Glogoski, M.S., OTR
Central Classroom Bldg., Rm. 203
Department of Occupational Therapy
San Jose State University
San Jose, CA 95192-0059

DESCRIPTION: We are interested in understanding how independent you are in community living skills. By helping us understand your view of how much assistance you need in community living skills, we will be better prepared to offer help to others who find themselves homeless.

RISKS AND BENEFITS: You may experience some mild discomfort when answering questions about the amount of help you think you need from others in order to live in the community. You may also experience discomfort when answering questions and doing tasks that you may not be familiar with or able to do. However, it is also possible that you will learn some useful information about how well you take care of yourself which can be shared with shelter staff or those who are trying to help you. You can decide if you want to share this information or not. We know of no other risks or benefits from this study.

TIME INVOLVEMENT: If you decide to participate, you will be given a questionnaire asking how much help you need from others to take care of yourself and you will be asked to answer some brief questions which will take about 45 minutes to complete. Later that day, or the following day you will be asked to participate in self-care tasks and asked to answer questions which will take about 60 minutes to complete. The study will take place at the Spring Street Shelter.

PAYMENTS: You will receive \$2.00 at the end of the first session and \$2.00 at the end of the second session.

SUBJECTS RIGHTS: If you have read this form and have decided to participate in this project, please understand that your participation is voluntary and you have the right to withdraw or stop participating at any time without penalty. You have the right to refuse to answer particular questions. Your individual privacy will be protected in all published or written data resulting from this study. Any information from this study that could be identified with you will remain confidential.

If you have questions about the study or want additional information you may contact Carolyn Glogoski (408) 924-3087 or (415) 328-0109. If you have questions about your rights as a study participant, or are unhappy at any time with any part of this study you may contact-without using your name if you wish-Lela Llorrens, Ph.D. (Chair, Department of Occupational Therapy) at (408) 924-3072, San Jose State University; or Denise Scatena, Ph.D. (Chair Human Subjects Committee) at (415) 841-9230, The Wright Institute, Berkeley, CA 94704. In the event that you have questions or complaints about research subject's rights or in the event of research related injury, contact Serena Stanford, Ph.D. (Associate Academic Vice President for Graduate Studies & Research) at (408) 924-2480.

I HAVE MADE A DECISION WHETHER OR NOT TO PARTICIPATE. I UNDERSTAND THAT CHOOSING TO NOT TAKE PART IN THIS STUDY WILL NOT AFFECT MY RIGHT TO RECEIVE SERVICES FROM THE SPRING STREET SHELTER AND THAT I CAN DECIDE TO DROP OUT OF THE STUDY WITHOUT AFFECTING MY RIGHT TO SHELTER SERVICES. MY SIGNATURE INDICATES THAT I HAVE READ THE INFORMATION PROVIDED ABOVE AND THAT I HAVE DECIDED TO PARTICIPATE. I HAVE RECEIVED A COPY OF THIS CONSENT FORM.

SIGNATURE _____ DATE _____

INVESTIGATOR'S SIGNATURE _____ DATE _____

A campus of The California State University

School of Applied Arts and Sciences • Department of Occupational Therapy
One Washington Square • San Jose, California 95192-0059 • 408/924-3070

CONSENT FORM

TITLE: SELF-REPORT OF COMMUNITY LIVING SKILLS

INVESTIGATOR: Carolyn Glogoski, M.S., OTR
Central Classroom Bldg., Rm. 203
Department of Occupational Therapy
San Jose State University
San Jose, CA 95192-0059

DESCRIPTION: We are interested in understanding how independent you are in community living skills. By helping us understand your view of how much assistance you need in community living skills, we will be better prepared to offer help to those who find themselves homeless.

RISKS AND BENEFITS: You may experience some mild discomfort when answering questions about the amount of help you think you need from others in self-care tasks. You may also experience discomfort when answering questions and doing tasks that you may not be familiar with or able to do. However, it is also possible that you will learn some useful information about how well you take care of yourself. We know of no other risks or benefits from this study.

TIME INVOLVEMENT: If you decide to participate, you will be given a questionnaire asking how much help you need from others to take care of yourself and you will be asked to answer some brief questions which will take about 45 minutes to complete. Later that day, or the following day you will be asked to participate in self-care tasks and asked to answer questions which will take about 60 minutes to complete. The study will take place at San Jose State University.

PAYMENTS: You will receive \$1.00 at the end of the second session.

SUBJECTS RIGHTS: If you have read this form and have decided to participate in this project, please understand that your participation is voluntary and you have the right to withdraw or stop participating at any time without penalty. You have the right to refuse to answer particular questions. Your individual privacy will be protected in all published or written data resulting from this study. Any information from this study that could be identified with you will remain confidential.

If you have questions about the study or want additional information you may contact Carolyn Glogoski (408) 924-3087 or (415) 328-0109. If you have questions about your rights as a study participant, or are unhappy at any time with any part of this study you may contact without using your name if you wish—Lela Llorens, Ph.D. (Chair, Department of Occupational Therapy) at (408) 924-3072, San Jose State University; or Denise Scatena, Ph.D. (Chair Human Subjects Committee) at (415) 841-9230, The Wright Institute, Berkeley, CA 94704. In the event of research related injury or questions or complaints about subject's rights, contact Serena Stanford, Ph.D. (Associate Academic Vice President for Graduate Studies & Research) at (408) 924-2480.

I HAVE MADE A DECISION WHETHER OR NOT TO PARTICIPATE. MY SIGNATURE INDICATES THAT I HAVE READ THE INFORMATION PROVIDED ABOVE AND THAT I HAVE DECIDED TO PARTICIPATE. I HAVE RECEIVED A COPY OF THIS CONSENT FORM.

SIGNATURE _____ DATE _____

INVESTIGATOR'S SIGNATURE _____ DATE _____

APPENDIX D
SCORABLE SELF-CARE EVALUATION

SCORABLE SELF CARE EVALUATION

The Maddak Award Winning
Book by E. Nelson Clark, MS, OTR.
and Mary Peters, MS, OTR.

SSCE Scoring Record

	Score		Maximum Possible Points
Personal Care	_____	1. Initial Appearance	8
	_____	2. Orientation	7
	_____	3. Hygiene	6
	_____	4. Communications	6
	_____	5. First Aid	24
	_____	SUBTOTAL	51
Housekeeping	_____	1. Foods Selection	26
	_____	2. House Chores	10
	_____	3. Safety	6
	_____	4. Laundry	15
	_____	SUBTOTAL	57
Work & Leisure	_____	1. Leisure Activity	4
	_____	2. Transportation	4
	_____	3. Job Seeking	4
	_____	SUBTOTAL	12
Financial Management	_____	1. Making Correct Change	4
	_____	2. Checking	11
	_____	3. Paying Personal Bills	5
	_____	4. Budgeting	10
	_____	5. Procurement of Supplemental Income	1
	_____	6. Source of Income	6
	_____	SUBTOTAL	37
Total Score	_____		157
Patient: _____			
Date Tested: _____			

Scorable Self-Care Data Record

	%	Total Score	Personal Care	House-keeping	Work & Leisure	Financial Mgmt.
FUNCTIONAL	100					
	95	5	2			
	90		4			
	85	10	6			
NEEDS SKILL DEVELOPMENT	80		7	1		
	75					1
	70		8	2		
	65					
PERCENTAGE	60	15				
	55		9			2
	50	19	10	5	.308	3
	45					
	40					
	35	20	11			
	30			6		4
	25		12	8		
	20			9		5
	15	25	13			
	10			11		
	5	30	14	14	1	6
DYSFUNCTIONAL					3	
	5	40		28	4	12
		50			5	
	0	60	30	40	6	14

NAME:

ADMINISTERED BY:

AGE:

SEX:

DATE:

DIAGNOSIS:

COMMENTS:

 Personal Care

1. Initial Appearance

Task: Observe whether client is dressed in appropriate seasonal clothing and practices personal hygiene.

Materials: Checklist

Instructions: Observe client according to checklist.

- _____ Clothing (mismatched or inappropriate for season)
 - _____ Makeup (excessive or inappropriate; unshaven: exclude proper beards)
 - _____ Dressing (pajamas or regular clothing not fastened)
 - _____ Maintenance of clothing (holes, tears, dirty)
 - _____ Cleanliness (presence of body odor, dirt)
 - _____ Hair (uncombed, dirty)
 - _____ Hands (dirty, include fingernails)
 - _____ Posture (rigid, laying head on table, slumped)
-

Scoring: _____ 1 point for each description that is present

Maximum Possible Points: 8

 Personal Care

2. Orientation

Task: Determine client's ability to read, write, and follow directions.

Materials: 1. Orientation Form
2. Pencil

Instructions: State: "Please follow the directions written on the form."

Personal Care

2. Orientation (continued)

Scoring: _____ 1 point for each error per category.
(information on wrong line, errors in spelling, incorrect date, time not within an hour, relative or friend not listed)

Maximum Possible Points: 7

PLEASE FILL IN FORM BELOW

Where are you located at this moment? _____

Sign your name _____

Your home address is _____

Your birthdate is _____

Draw hands on the clock to tell what time you think it is now.

Today's date is _____

Name of nearest relative or friend _____

Personal Care

3. Hygiene

Task: Determine frequency of daily hygiene

Materials: Checklist

Instructions: State: "How often do you think you or someone else should perform the following activities?"

Take a shower or a bath	_____
	(TWICE A WEEK)
Wash face	_____
	(ONCE A DAY)
Shampoo hair	_____
	(TWICE A WEEK)
Comb or brush hair	_____
	(DAILY)
Brush teeth	_____
	(DAILY)
Shave or trim beard (Do not score point if client does not have a beard)	_____
	(DAILY AND MONTHLY)

Scoring: ____ 1 point for less than minimum suggested standards.

Maximum Possible Points: 6

Personal Care

4. Communications

Task: Determine knowledge of use of telephone in locating emergency numbers and location of medical facilities.

Materials: Telephone book that includes the yellow pages and six (6) 3 x 5 cards with one of the following titles printed on each card:

Personal Care

4. Communications (continued)

- A. Rescue squad or ambulance
 - B. Fire and police
 - C. Business number (use a familiar name)
 - D. Doctor or family physician
 - E. Dentist
 - F. Clinic or hospital
-

Instructions: Display each card for two minutes and ask the client to locate each number in the telephone book.

Scoring: _____ 1 point for incorrect answer or inability to locate number within two minutes.

Maximum Possible Points: 6

Personal Care

5. First Aid

Task: Determine client's knowledge of initial emergency care.

Materials: Interview checklist

Instructions: Read aloud the following scenarios and questions. Encourage the client to discuss his responses to each situation

- A. Mouth-to-mouth artificial resuscitation

State: "Pretend that you have discovered someone unconscious, his breathing is very weak and he looks grayish-blue. Can you describe the steps or procedures to do mouth-to-mouth resuscitation?"

1. Tilt head of victim back
2. Pinch victim's nose closed
3. Form air seal and blow into victim's mouth

Personal Care

5. First Aid (continued)

4. Remove your mouth and observe victim's chest exhale
 5. If air is not being exchanged, look for foreign matter lodged in throat
-

Scoring: ____ 1 point for each step not described

B. Shock

State: "Shock is a condition of the body failing to function due to lack of blood circulating after severe injury. Can you describe what you would do if you discovered someone who had been seriously injured and was in shock?"

1. Have the victim lie down
 2. Keep the victim warm (cover him and have him lie on something warm)
 3. Give him something warm to drink in small doses
 4. Reassure the victim
 5. Call for help
-

Scoring: ____ 1 point for each step not described

C. Bleeding

State: "How do you stop bleeding, such as a bad cut or a nosebleed?"

1. Apply pressure
 2. Bandage
 3. Cold/ice compresses
-

Scoring: ____ 1 point for each step not described

D. Burns

State: "Sunburns are unpleasant and can be very dangerous. Do you know how long you can stay out in the sun on your first seasonal visit to the beach or during suntanning?"

Personal Care

5. First Aid (continued)

Scoring: ____ 1 point for answer more than 30 minutes

State: "What would you do if you or someone else burned themselves very badly, such as a second- or third-degree burn?"

1. Second-degree burns (red skin and blisters): Immerse in ice water, then cover
 2. Third-degree burns (loss of skin and sensation): Cover in sterile dressings, wrap in plastic to exclude air
 3. Seek medical help
-

Scoring: ____ 1 point for each description omitted

E. Drugs

State: "What would you do if you suspected that someone had overdosed on drugs and was in danger of dying?"

1. Keep the victim awake and moving
 2. Give artificial resuscitation if needed for breathing
 3. Maintain body heat
 4. Reassure the victim calmly and protect him
 5. Seek professional help for victim as soon as possible
-

Scoring: ____ 1 point for each step not described

F. Choking

State: "What would you do if you saw someone choking on food?"

1. Slap victim on back
2. Use Heimlich maneuver
3. Call emergency number, operator, or professional help

Personal Care

5. *First Aid* (continued)

Scoring: _____ 1 point for not describing *any* of the steps above

G. Sickness

State: "What would you do if you were very ill and did not understand why you were sick?"

1. Contact friend for assistance
 2. Call emergency medical service
 3. Seek professional help
-

Scoring: _____ 1 point for not describing *any* of the steps above

Maximum Possible Points: 24

Housekeeping

1. *Foods Selection*

Task: Determine client's ability to plan balanced meals

Materials: Menu form and pencil

Instructions: State: "I would like you to plan your meals for two days. You can plan as though you are eating at home or eating out in a restaurant. Please fill out the form according to your usual eating habits and the approximate amount of money you spend each month."

The recommended portions/servings of the FOUR BASIC FOODS (as recommended by the National Dairy Council) in order to meet a balanced daily diet are as follows:

1. MILK GROUP — Includes ice cream, cheese, creamed soups, and so forth.
Serving: 3 glasses or servings.

Housekeeping

1. Foods Selection (continued)

2. MEAT & EGGS — Includes fish, meats, peanut butter, high protein foods. *Servings: 2 or more.*
3. VEGETABLES & FRUIT — Includes green and yellow vegetables and various fruits. *Servings: 4 or more.*
4. BREAD — Includes cereals, crackers, a variety of breads, cakes, and so forth. *Servings: 4 or more.*

Scoring: _____ 1 point for each serving in each category *below* minimum requirement.

Example:

Breakfast	Lunch	Dinner
0 Coffee	2,3,4 Hamburger	2 Fried Chicken
	3 Fries	3 Corn
	0 Coke	1 Glass of milk
		1,4 Bread & butter
		3 Salad
		1,4 Cake & ice cream

The above menu lists the four basic food groups for each entry. Numbers in front of foods represent food groups to which that food belongs.

Milk Group: 3, Meat Group: 2, Vegetables Group: 5, Bread Group: 3

The score is one (1) for the sample menu. 1 point is assigned for one entry below the recommended serving (in this case, the bread group).

Maximum Possible Points: 26

<i>Menu</i>		
Breakfast	Lunch	Dinner
1st Day		
2nd Day		
Snacks		
comments		

Housekeeping

2. House Chores

Task: Determine client's ability to organize and sequence household tasks

Materials: Ten 3 x 5 cards with the following tasks typed or printed on each card

1. Clear table
 - *2. Scrape scraps from dishes into garbage container
 - *3. Put unused food into refrigerator
 4. Wash dishes
 5. Wash pots and pans
 6. Dry dishes and utensils
 7. Place dishes and utensils into storage
 8. Wipe off stove, table, counters (may precede drying utensils and dishes)
 9. Sweep floors
 10. Watch television or enjoy self
-

Instructions: State: "Please pretend that you have just eaten a meal. You are going to do the household chores that usually follow a meal. Please place the chore cards in the order that you would perform them following your meal."

Scoring: ____ 1 point for each card in improper order other than suggested

Maximum Possible Points: 10

*May be

Interchangeable

Housekeeping

3. Safety

Task: Assess client's judgment or dangerous situations

Materials: 6 safety precaution cards

Instructions: Show each card to the patient and ask: "If you see anything dangerous in this picture, please tell me."

1. Cutting grass with no shoes on
 2. Standing in rocking chair
 3. Tripping over misplaced toys
 4. Operating power equipment without safety glasses
 5. Crossing street against light
 6. Sitting in chair (nothing wrong in this picture)
-

Scoring: ____ 1 point for each incorrect response

Maximum Possible Points: 6

Note: Remove the following three pages and clip into individual cards for convenience.

4. Laundry

Task: Determine client's ability to make a list, exercise shopping judgments, follow directions, and sequence laundry tasks.

Material: Laundry list form and pencil

Instructions: State: "Please fill out this laundry list form."

ANSWERS TO LAUNDRY LIST:

The following three answers must be listed: Laundry, washing powder, and change (money). Additional answers could be: Basket, fabric softener, bleach, reading material.

2. Supermarket (most generally the prices are cheaper)
3. Whites and colors
4. B (some machines are different from others and need individual instructions)
5.
 1. Place laundry in machine
 2. Measure laundry soap and add to wash
 3. Put money in coin slot
 4. Add bleach to whites
 5. Add softener during rinse cycle
 6. Remove clothes after final spin cycle
 7. Shake out clothes and place in dryer
 8. Remove clothes from dryer
 9. Fold clothes
 10. Job done

Note: This particular sequence is used to avoid accidental starting of laundry machine without clothes and soap in machine.

Scoring: _____ 1 point for incorrect answer or misplaced sequence

Maximum Possible Points: 15

LAUNDRY LIST

1. List 5 things you need to take to the laundromat in order to do your laundry.

2. Check the most economical place to buy your washing materials:

(A)____All-night convenience store, (B)____At the laundry, (C)____Supermarket, (D)____Service station

3. Separate your laundry into two loads/piles. What are they?

4. Before loading the machines and washing clothes, what must you read?

(A)____Magazine, (B)____Instructions for washing clothes in laundry, (C)____Newspaper ads; (D)____Soap box

5. Arrange the following tasks in numerical order:

Example: _____ Place laundry in washing machine
 _____ Fold clothes
 _____ Pour bleach into washing machine filled with water
 _____ Put money into machine coin slot
 _____ Shake out clothes and place in dryer
 _____ Add softener during rinse cycle
 _____ Measure laundry powder and place in machine
 _____ Remove clothes after final spinning cycle
 _____ Remove clothes from dryer when they are dry
 _____ Job done, pack up, enjoy self

Work and Leisure

1. Leisure Activity

Task: Interview to determine client's leisure habits

Instructions:

- A. State: "Describe what you do when you're not working. In other words, how do you spend your spare time?"

Scoring: _____ 1 point for less than two activities

- B. State: "What activities or hobbies do you think you might be interested in?"

Scoring: _____ 1 point for no interests

- C. State: "When is the last time you participated in hobbies or sports?"

Scoring: _____ 1 point for not having performed an activity within the last two weeks

- D. State: "Do you participate in any of these activities with other people?"

Scoring: _____ 1 point for negative answer

Scoring: _____

Maximum Possible Points: 4

Work and Leisure

2. Transportation

Task: Interview to determine client's mobility and ability to use a map

Materials: Map of local city

Instructions:

A. State: "How do you travel from one destination to another or wherever you need to go?"

Scoring: ____ 1 point for response of walking only, borrowing car, or asking acquaintances for rides without reciprocating actions.

B. State: "Please describe how you would find out or get information on riding buses or subways to unfamiliar locations."

Scoring: ____ 1 point for inability to identify or describe bus stop/routes, phone numbers, asking bus driver, and so forth.

C. Hand map of "local" city to patient and ask: "Please locate _____ street on this map." (Pick a street that the client would have to refer to street index in order to find.)

Scoring: ____ 1 point for inability to locate street within two minutes.

D. State: "What road/street is this (hospital, building, institution, office) located on?"

Scoring: ____ 1 point for incorrect or no response

Scoring: ____

Maximum Possible Points: 4

Work and Leisure

3. Job-Seeking Skills

Task: Interview to determine employment plans

Instructions: If client has indicated that he has a job and will return to the same job, STOP. Score this section zero and proceed to next section.

If client indicates that he has previously worked but has no future employment plans, or if client is on social security insurance, inquire:

1. When did you last work?

Scoring: _____ 1 point for inability to recall when last worked

2. Describe the work that you do.

Scoring: _____ 1 point for inability to describe work skills

3. Do you feel that you are capable of resuming the same kind of responsibilities when you return to work?

Scoring: _____ 1 point for inability to respond appropriately

4. Describe ways to find work.

Scoring: _____ 1 point for inability to describe two sources, such as locating work through newspapers, employment agencies, or friends.

Scoring: _____

Maximum Possible Points: 4

Financial Management

1. Making Change

Task: Determine client's ability to make change when purchasing items.

Materials: 1. U.S. coins and bills or "play" money
2. A magazine priced at \$1.75 and a tax tag of .03 cents (can be placed on magazine by therapist)

Instructions:

A. Making Change

Place a box of coins on the table in front of the client. State: "I am going to place some money on the table. Please give me the correct coins that will equal this money." Place a one dollar bill on the table. If client uses all quarters, request change other than quarters.

Scoring: _____ 1 point for failure to make correct change

B. Buying Items

State: "In this task, I am going to ask that you purchase this magazine from me."

Step 1: Give patient two one dollar bills

Step 2: State: "This magazine costs \$1.75 plus .03 cents tax. What is the total cost?"
STOP. If client is unable to respond, stop and Score 3.

Step 3: Hand client the magazine. Request that he give you the money. STOP. If client is confused or responds incorrectly, stop and Score 2.

Step 4: Return correct change to client (22 cents). Ask client to count change. Is it the correct amount? STOP. If client responds incorrectly, Score 1.

Scoring: _____

Maximum Possible Points: 4

Financial Management

2. Checking

Task:

- A. Determines whether client can write all required entries on a check correctly.
 - B. Determine whether patient can record correct entries in the proper places and do the math necessary to balance the check register.
-

Materials: Check and register form

Instructions:

- A. Hand the patient a check form and a pencil. Ask the patient to write a check to the Mobile Oil Service Station for \$23.82.
 - 3. Ask the patient to record the amount in the proper place and do the math to balance the register (balance is \$9.12).
-

Scoring: _____ 1 point for each incorrect or absent entry. (There are 11 appropriate entries on the check form and register.)

Maximum Possible Points: 11

Authors' Note: The purpose of this task is to determine a knowledge of banking skills.

BE SURE TO DEDUCT ANY PER CHECK CHARGES OR ANY BALANCE CHARGES THAT MAY APPLY

DATE	CHECK NUMBER	CHECKS ISSUED TO OR DEPOSIT RECEIVED FROM	AMOUNT OF DEPOSIT	✓	AMOUNT OF CHECK	BALANCE	
						32	94

NON-NEGOTIABLE PRACTICE CHECK Any Bank 10

_____ 19 _____

PAY TO THE ORDER OF _____ \$ _____

_____ DOLLARS

Financial Management

3. Paying Personal Bills

Task: Determine client's ability to assume financial responsibility for personal bills

Materials: Bill form

Instructions:

Hand the bill to the client.

State: "Who is responsible for paying this bill?" (O.T. CLINIC)

"Who sent this bill?" (ELECTRIC COMPANY)

"How much is the amount due on this bill?" (\$27.68)

"How would you pay this bill?" (checks can be mailed to correct location, cash should be presented in person at correct location)

"Where are the locations that you can pay this bill?" (ELECTRIC CO. OFFICE—DESIGNATED LOCATIONS)

Scoring: ____ 1 point for each incorrect answer

Maximum Possible Points: 5

The Electric and Gas Company POB OO Anywhere St., Mytown, Ourstate 94128

Please refer to
your account
No., when making
inquiries

12 90 3235 0540

Acct. #

Aug 15 81 2970

Bill Date

Credit

2970CR 00

07122	Service Address	Meter	Charges
	O.T. CLINIC	Reading	
	POB 777	8770	Electric
	Rehab St	7587	Gas
	Independence	540	Ele Fuel Adj
		7	Gas Cost
			State Sales Tax
			20.38
			2.61
			2.99
			.64
			1.06

Special Message
If not paid in 14 days your
electricity will be shut off

Please pay 27.68
Please deduct any recent
payments not reflected

Financial Management

4. Budgeting

Task: Interview to determine client's ability to budget monthly income and complete budget form. Interview may be in conjunction with the process of completing the budget form.

Materials: Budget form and pencil

Instructions: Place budget form and pencil in front of client. State: "Following each expense item, please fill in the blanks with how much you spend for this item in one month. You may estimate the costs by sharing expenses with roommates or a family if you are responsible for or participate in a family's expenses. Please indicate on your budget worksheet whether you are planning this budget according to cost sharing, living alone, or living with your family."

Scoring: _____ 1 point for each response exceeding high or low budget estimates.
Example: Housing \$150–500. A point would be scored for a figure less than \$150 or more than \$500
_____ 1 point for exceeding the budget by 5%
_____ 1 point for a budget less than the given income by 5%

Maximum Possible Points: 10

Budget Estimates: Note: The figures given were used in a high-cost area of living. We recommend that each therapist adjust these figures to her area's cost of living standards.

Financial Management

4. Budgeting (continued)

	Sharing	Self	Family
Housing	100-500	200-700	250-1500
Gas, Water, Lights	25-100	60-200	75-200
Travel	50-300	50-300	50-500
Clothing	10-100	10-100	30-200
Food	115-300	115-300	270-500
Personal Pleasure (movies, clubs)	5-100	5-100	15-250
Savings	0-500	0-500	0-500
Incidentals (loans, church, gifts)	0-200	0-200	0-200

Monthly Budget Worksheet

This budget is planned for:

- ☐ Living Alone
- ☐ Sharing Costs (roommates)
- ☐ Family Expenses

Housing (mortgage, rent, share) _____

Gas, Water, Electricity, Phone _____

Travel (car, bus, subway) _____

Clothing (washing, buying, repairing) _____

Food (include eating out) _____

Personal Pleasure (movies, books, snacks) _____

Savings _____

Incidentals (loans, church, gifts, various expenses) _____

Estimate your present income: _____

Financial Management

5. Procurement of Supplemental Income

Task: Interview client to determine knowledge of financial assistance programs

Instructions:

State: "Do you know what social security or food stamps are?"

Scoring: ____ 1 point for a "NO" response. STOP. Instruct patient during self-care rehab program about assistance programs.

If "YES" response, please proceed.

State: "Have you ever used public assistance, or are you presently using food stamps?"

If "YES", ask: "Where did you apply to receive assistance?" (social services, public assistance, and so forth)

Scoring: ____ 1 point for incorrect response

If "NO", ask: "Where would you go for public financial assistance?" (look up public assistance in phone book, social services, and so forth)

Scoring: ____ 1 point for inaccurate response

Maximum Possible Points: 1

Author's Note: As the costs of food, housing, and medical care increase, a greater number of our clients need and qualify for federal assistance. For example, some individuals may need food stamps to supplement a budget to supply foods needed for good nutrition. The authors believe that a knowledge of financial programs is important for some disabled populations.

Financial Management

6. Source of Income

Task: Determine client's income source and ability to collect from that source

Instructions:

State: "Are you receiving a check from anyone?"

If "YES", ask: "Who pays you?"

If "NO", ask: "How do you obtain the money you use to live?"

Scoring: _____ 2 points for a response of money being provided by another person, such as wife/husband, parents, or relatives.

_____ 1 point if client is unable to work or has no plans to secure a job. STOP.

If client identifies a pension, public assistance, or social security check as a source of income, State: "If your check didn't get to you, what would you do to locate it?"

Scoring: _____ 2 points for incorrect response

_____ 1 point if patient does not know location of office

If client identifies work, job, or employment as source of income, state: "When do you plan on returning to work?"

Scoring: _____ 3 points if client has no employment, and/or does not want to return to work. STOP.

_____ 1 point if client is presently not working (lost job) but has plans to return to work. (Plans to return to work must be within four weeks of termination of inpatient hospitalization.)

Maximum Possible Points: 6

APPENDIX E

LETTER APPROVING USE OF SCORABLE SELF-CARE EVALUATION

A CAMPUS OF THE CALIFORNIA STATE UNIVERSITY

School of Applied Arts and Sciences • Department of Occupational Therapy
One Washington Square • San Jose, California 95192-0058 • 408/277-2684 924-3070

January 16, 1992

Harry Bensen
Slack Incorporated
6900 Grove Rd.
Thorofare, NJ 08086
FAX: (609) 853-5991

Dear Mr. Bensen:

I would like to request permission to reproduce the publication: Scorable Self-Care Evaluation Manual by Nelson Clark and Mary Peters (1984) for research purposes. I am an assistant professor at San Jose State University and will be conducting research with two graduate students on the chronic mentally ill homeless population using the Scorable Self-Care Evaluation as one measure. My need to reproduce the manual is threefold. I need to reproduce portions of the manual for (1) inclusion in human subjects proposals to institutional review boards for permission to do the research considering its impact on the subjects (2) my research assistants use in data collection, (3) inclusion in masters thesis presented to the University by the graduate students. I look forward to hearing from you as soon as possible. If you have any questions please call me at H (415) 328-0109 and after January 20th at work (408) 924-3087.

Sincerely yours,

Carolyn Glogoski
Carolyn Glogoski
Assistant Professor
San Jose State University

Jan. 16, 1992

Dear Ms. Glogoski:
You have my permission to use the SSCE material as requested. There will be no permission fee, however you may not resell the material at a profit. Your use is granted for the educational and research purposes listed above. Good luck with your project! Harry Bensen

APPENDIX F
SEMI-STRUCTURED INTERVIEW

INTERVIEW QUESTIONS

1. What are some of the things that you do that you think are important to help you survive when you are living out on the streets?
2. What is your greatest need at this time?
3. What are some things that you might like to learn to help you to survive better? (if you could learn this through the shelter would you attend a class or program?)
4. What do you think the shelter could offer?
5. Do you want to live somewhere other than the streets?
6. If you had a chance to get off of the streets permanently in what kind of place would you like to live?
7. What community living skills do you think are most important in order to live in a place permanently? least important?
8. How has being homeless affected your physical and mental health?