1992

Ending Homelessness Among Women with Severe Mental Illness: A Model Program from Philadelphia

Dennis P Culhane, *University of Pennsylvania*

Ending Homelessness Among Women with Severe Mental Illness: A Model Program from Philadelphia

Dennis P. Culhane

Dennis P. Culhane, Ph.D., is Research Assistant Professor of Psychology in Psychiatry, University of Pennsylvania, in Philadelphia.
Address correspondence to Dennis P. Culhane, Ph.D., Section on Public Psychiatry and Mental Health Services Research, 3600 Market Street, Room 716, University of Pennsylvania, Philadelphia, PA 19104-2648.

Abstract: The literature on homelessness among persons with severe mental illness suggests that successful programs for ending homelessness should be both comprehensive in scope and highly responsive to the perspectives of homeless people. Women of Hope is one such program in Philadelphia, which was initiated to serve "noncompliant," treatment-resistant homeless women with mental illness who have a history of living on the streets. Through aggressive outreach and a low-demand congregate housing program, Women of Hope has been successful in bringing 120 women off the streets. Residents are required neither to undergo treatment nor to stay in the program, but are encouraged over time to seek mental health services and medical treatment. Former residents can be found primarily in independent housing and secondarily in highly and moderately structured housing. A diverse range of housing types has been required to place residents, including use of the congregate housing program as a permanent option. Approximately 14% of the former residents have returned to living on the streets, but continue to receive outreach services.

Recent research suggests that there may be a solution to the homelessness of persons with severe and persistent mental illness (Blankertz, Cnaan, & Saunders, in press; Lipton, Nutt, & Sabatini, 1988). Despite pessimism about the "intractable" nature of homelessness and other urban social ills, innovative programs have demonstrated that, with the right combination of resources and services, people who are homeless and who have mental illness can have a future free from the indignities of street life. Such programs that are effective in resolving homelessness are important, not only for what they accomplish, but for what they might suggest as preventive strategies as well. Therefore, this paper reports on one such program, in which homeless people with mental illness are assisted in their transition to more appropriate living arrangements. By describing the history, structure, and outcomes of "Women of Hope" community housing in Philadelphia, this paper reflects on the essential components of an

effective program to end homelessness among people with severe mental illness, and on the continuing needs of persons who must confront both mental disability and residential instability.

Assessing the Service Needs of Homeless Persons with Severe Mental Illness

Several factors have contributed to the failure of most existing programs to end homelessness among people with severe mental illness. First, because of limited resources, most programs serving the homeless are crisis-oriented and time-limited; therefore, ending homelessness is typically not even a stated service goal. Second, services to the homeless are usually uncoordinated, involving multiple providers with widely different perspectives and approaches (Hagen & Hutchinson, 1988). Third, the homeless report a low utilization of traditional community mental health services (Roth & Bean, 1986; Morrissey & Dennis, 1990; Rog, 1988), thereby joining the ranks of the "underserved" or "noncompliant." Fourth, homeless people and mental health professionals tend to disagree on the priority of various services: "Homeless mentally ill persons tend to place a high priority on meeting their basic subsistence needs first, before addressing their mental health needs, whereas mental health professionals often place a higher priority on providing traditional mental health treatment" (Levine & Rog, 1990; p. 964). Hence, efforts aimed at ending homelessness among people with severe mental illness and at treating mental illness among the homeless require new service strategies that go beyond emergency care, that have the stated intention of ending homelessness, that include some greater coordination of services, and that consider the perspectives of homeless people in the design of services.

This need for a more comprehensive approach to service delivery for people who are homeless and have mental illness has been recognized by the National Institute of Mental Health (NIMH) and the U.S. Congress. Based on 20 NIMH-supported pilot demonstration projects focused on the development of discrete community services, such as case management and outreach, for people with mental illness. Levine and Rog (1990) have concluded that "discrete service elements cannot address the multiple, diverse, and extensive needs of the homeless mentally ill population. . . . The experiences of these projects . . . suggest the need for a more comprehensive approach to service delivery" (pp. 964–965). In other words, while case management is necessary for guiding homeless people through the labyrinth of providers and agencies, a case manager cannot magically produce community resources that are simply not available, such as affordable, accessible housing. Similarly, outreach efforts without follow-up programs that go beyond emergency food and shelter are of

insufficient scope to have an impact on the homelessness of people with mental illness.

Similarly, the Stewart B. McKinney Homeless Assistance Act authorized by the U.S. Congress recognized this need for a more comprehensive approach in the provision of services to people with mental illness who are homeless (Levine & Rog, 1990). Through the Community Mental Health Services Demonstration Program for Homeless Individuals Who Are Chronically Mentally Ill, competitive grants were awarded to 9 projects that proposed to design comprehensive services for people with mental illness who are homeless (Title VI, Section 612). Likewise, the McKinney Act authorized funding through the noncompetitive block grant program to states which provide comprehensive services to homeless people with mental illness (Title VI, Section 611). In both cases, "comprehensive services" were to include the following: outreach services in nontraditional settings; intensive, long-term case management; mental health treatment; staffing and operation of supportive living programs; and management and administrative activities that coordinate the above services. Hence, homelessness among people with mental illness has challenged the community mental health system to be comprehensive, and is demonstrative evidence that, in many cases, it currently is not.

Finally (and this is equally, if not more important than the comprehensiveness of the services), research suggests that a different planning perspective is required to make these services fit the material and perceptual framework of homeless persons (Ball & Havassey, 1984; Lipton, Nutt, & Sabatini, 1988), challenging the mental health system to refocus its concern for the "noncompliant" client to the "noncompliant" system of care. Existing research has found that a more consumer-driven process is needed in the design of services for people with mental illness who are homeless. Contrasted with the traditional "treatment plan" approach, whereby the service provider designs a program of service with which the client complies, thus producing a successful outcome, successful outcomes among the homeless have been found to require meeting the homeless "on their own turf" (First, Rife, & Kraus, 1990), following the lead of "consumer initiated participation" (Pollio, 1990), and with attention to "individualized service delivery" (Blankertz, Cnaan, & Saunders, in press). Goering, Durbin, Trainor, and Paduchak (1990) describe one such model for ending homelessness among women with serious mental illness that similarly places an emphasis on consumer involvement and the development of normalized, independent living: "permanent housing with flexible supports rather than residential treatment programming" (p. 37). Borrowing from models of health behavior, Dattalo (1990) has similarly theorized on designing services for the homeless by accommodating to the health beliefs of the targeted consumers.

Thus far the literature describing the design of model programs for the homeless has been primarily theoretical (Dattalo, 1990). Few investigators have examined what housing programs actually work in ending homelessness among people with mental illness or the range of housing that has proven necessary (Blankertz, Cnaan, & Saunders, in press); fewer still have detailed how such a program is developed. Therefore, this paper will describe the development and outcomes of one such program in Philadelphia called "Women of Hope." The program has been labelled a "low demand respite" residence (LDR) by the local mental health authority because it was initially developed as an open door to homeless "street people," and would have few rules and no treatment requirements placed on residents.

Women of Hope: Its History and Program

Philadelphia, like cities throughout the United States and North America, experienced a significant increase in its homeless population beginning in the early 1980s, with public shelter capacity alone growing from approximately 250 beds in 1982 to 5,400 beds by 1988 (Office of Services to the Homeless and Adults, 1991). Among this growing homeless population, a highly visible subgroup of street people was recognized, consisting of an estimated 400 persons in 1989 (Ferrick & Odom, 1989). City officials estimate that approximately half of the street population at any given time, or 200, are persons with serious mental illness (Office of Services to the Homeless and Adults, 1990). Sr. Mary Scullion, co-founder and director of Women of Hope, estimates that there were approximately 60 to 70 women with serious mental illness among this highly visible street population in 1985.

In response to this growth, the Sisters of Mercy and Catholic Social Services in Philadelphia sponsored "Mercy Hospice," a shelter dormitory and day program for women living on the street. But staff members at Mercy Hospice, including Sr. Mary Scullion, recognized that this shelter program, and others like it throughout the city, were insufficient to meet the needs of the seriously mentally ill street population. First, most shelters were overwhelmed with demand for services by persons who did not have mental illness, subsequently intimidating or even screening out many persons with serious mental illness by having rules and requirements with which some individuals had difficulty complying. For example, some shelters allowed entrance to people with mental illness only if they were willing to undergo psychiatric evaluation; other shelters had compulsory lice treatment as a condition of entrance for street people; and most had numerous rules regulating access to resources and governing "inappropriate" behavior. Second, because of their structure as temporary

shelters, most homeless programs failed to end homelessness among people with serious mental illness by presuming that temporary services were sufficient. However, without follow-up components, these shelter programs actually helped to condition the residential instability of the population, even enforcing it by limiting the length of stay and hours of daily operation. Third, exacerbating the constraints of homeless services, existing public mental health programs were unable to end homelessness among people with serious mental illness because enrollment in "day programs" or being "in treatment" was (and still is) a necessary condition for getting into community mental health residences in Philadelphia. Since many of the homeless with serious mental illness were not ready to participate in such programs, either due to the fears of compulsory hospitalization, victimization, or other, less clearly articulated fears, they were effectively excluded from having access to housing through the mental health system. Consequently, existing homeless and mental health programs, while perhaps well intentioned, often failed to prevent people with serious mental illness from living on the streets. Instead, they served as yet another source of rejection and further confirmation to the homeless that human service agencies are a bureaucratic maze of little relevance to the circumstances of homeless people.

Recognizing these limitations, Women of Hope was established in March, 1985. The target population was homeless women with serious mental illness who had spent a year or more living on the streets. The program was initiated to assist those women who were the most "noncompliant," the most "treatment-resistant," and, consequently, those who were not being served by existing agencies. Intended as a short-term respite for women on the streets, few demands would be made by staff members (i.e., no physical violence, no smoking in bedrooms), and there would be no requirements for treatment. Hours of operation would be from 6 p.m. to 10 a.m. An aggressive outreach component was included to make women aware of the program, to befriend them, and to assure them that they would be free from compulsory treatment and arbitrary disciplinary actions.

The Women of Hope staff first sought clients from among the women on the street whom they knew had limited and unsuccessful contact with the Mercy Hospice program. They also tried to identify all other women with serious mental illness who were living on the streets of Philadelphia. In an ambitious, daily effort that continues, outreach staff members maintain contact with the women whom they identify, and offer them food, blankets, and, if they are receptive, a place to stay with Women of Hope. In some cases it has taken months or even more than a year before a person might accept the offer of Women of Hope's assistance. As has been reported

elsewhere (Rog, 1988), outreach efforts to homeless people with mental illness demand patience, an ability to gauge the individual's readiness for assistance, and, most importantly, building a relationship of trust over time.

Women of Hope's outreach effort has also required constant monitoring for the arrival of new persons. However, after several years of serving women with serious mental illness on the streets, the impact of Women of Hope and other "low demand residences" has been so obvious as to reduce substantially the number of women who require outreach services. Indeed, Sr. Mary Scullion notes that at one time in 1990, to her knowledge, there were only six women with serious mental illness sleeping on the streets of Philadelphia, and the outreach team knew who they were, knew where they were sleeping, and were working to bring them into the program. The net effect has been to reduce the number of women with serious mental illness who are street people, with outreach targeted primarily at new arrivals. Unfortunately, the outreach team has noted recent increases in those arrivals, particularly among younger women.

New residents are incorporated into Women of Hope at their own pace. Staff members first observe new arrivals and let them acquaint themselves with other residents and staff members. People are not forced to shower, attend programs, or stay. Fragile relationships are allowed to form over time. When Women of Hope began, it was assumed that this limited assistance would be appropriate. However, just as soon as women started accepting the assistance of Women of Hope, they began to make demands of the program. First, they wanted 24 hours of operation, not just the nighttime hours that were initially planned and that are so typical of shelter services. They wanted, and were allowed, to come and go as they pleased, with no requirements to be back by a certain hour, and with no threat of sacrificing their placements by not returning. Some saw Women of Hope as their home; others used it as a stable supplement to the networks they had established on the streets. And for many of the women, at least initially, it was simply a place where they were accepted without hassles, and where they could find refuge from the streets. Whatever its role, the staff attempted to accommodate the structure to the functions it was serving. The women's needs and preferences became the basic building blocks by which the informal programs grew.

Having succeeded in winning the confidence and trust of more than a dozen homeless women in their first month of operation, the staff from Women of Hope noticed the need for additional services and began to "network" with other community agencies. Women of Hope forged a relationship with a local community mental health center, Hall Mercer, which agreed to provide mental health services to the women in residence, on site, five mornings a week, and with on-call crisis services available 24

hours a day, seven days a week. When relationships and confidence grew, staff members would make residents aware of the availability of mental health services; however, treatment was not required or forced, but recommended and encouraged. Staff members also sought consultations with physicians and other mental health professionals on how to manage the medical and social needs of individual residents. Where necessary and possible, medication regimens have been established. The need for on-site mental health services has lessened over time due to the stability of the women and the growing experience of staff. Currently, most of the women receive outpatient services from Hall Mercer, and a counsellor from the community mental health center is on site only one day a week.

In time, other relationships have also formed with the community. For example, a nurse from the Philadelphia Heath Management Corporation (PHMC) offers her services to residents once a week. The nurse works to develop health care goals for each resident, and also uses her time to help educate the staff on certain health and safety policies within Women of Hope. Visiting the nurse is not compulsory, but is encouraged, especially through the nurse's cordial and informal relationship with the residents. Yearly physicals are also now available to the women through PHMC, although it does take a significant amount of time to get to this point for many residents. Alliances have also formed with political advocacy groups engaged in work around homeless issues, including groups of homeless people and mental health consumers. In fact, residents and staff members have joined together in "sleep-outs" at the State Building, in vacant building "takeovers", and at "speak-outs" and protests before public administrative offices.

The staff members at Women of Hope also works with each of the women to establish an income. This includes a review of public and private benefits eligibility and of any potential employment opportunities. Several of the women work at the residence, others in the neighborhood, and still others for affiliated human service agencies. Since many of the women are eligible for SSI or other income support programs, the women are also asked to contribute rent toward the cost of their housing. For example, rent is capped at 55% of SSI benefits for SSI recipients. This compares favorably with several of the boarding homes in the city's shelter system, which are allowed to keep up to 70% of clients' monthly SSI income, and, in some cases, people receive only $25 a month. This paltry sum has tended to make clients completely dependent on providers, and has motivated some persons to avoid the boarding home system.

Regular team meetings of Women of Hope staff members, the nurse, and Hall Mercer mental health workers monitor the life skills of residents and create an informal plan to encourage improvements in life skills. Although

most of the women are able to improve their performance of daily living tasks with the support of the staff, some of the women have remained resistant, and have either maintained a poor condition, or have even regressed. While not encouraged, such "noncompliance" is allowed and tolerated. However, in a few cases, involuntary commitment has been sought for those persons who threatened their own or others' well-being and safety. Following stabilization in the hospital, such persons are welcomed back to Women of Hope if no other appropriate residential plans have been made.

Finally, Women of Hope works to locate permanent housing for its residents, taking account of individual needs and preferences. For example, some residents have expressed a desire for greater independence and control over their housing, while still others seek or require more supervised housing. Other residents have not wanted to move from Women of Hope because the available alternatives were perceived to be unaffordable or lacking in a network of support. Regardless, staff members and residents face a continual problem of an inadequate housing supply. Therefore, a group of residents, staff members, and volunteers at Women of Hope has recently launched a program dubbed "Project HOME (Housing, Opportunities, Medical care, and Employment)." Project HOME is a nonprofit housing development corporation seeking to build supported housing for men and women with mental illness who have a history of homelessness. Project HOME has already begun construction of a 48-unit single room occupancy (SRO) housing program in which women would be independent of Women of Hope, yet avail themselves of the network of support it provided. The project has encountered some opposition from a neighborhood civic association and is currently in litigation to determine its fate. (It should also be noted that some of the women choose to stay at Women of Hope's congregate residences regardless of what is offered, and this use as a "permanent residence" has been accommodated.)

Since its inception in 1985, Women of Hope has doubled its initial capacity of 24 by creating another residence. Staff development has included more mental health professionals, social workers, and mental health aides who are former Women of Hope residents. Most of the current staff members are women who have a commitment to helping the residents achieve their goals, and most of the staff members are not Sisters of Mercy. The program at Women of Hope has evolved to look very much like what might be called "comprehensive services" in the professional literature, including outreach services, basic material assistance, mental health treatment, case management, medical care, daily living skills training, and employment and financial assistance, delivered to each individual according to her individually prescribed needs.

When asked to describe what made Women of Hope a success, Sr. Mary Scullion and Sr. Marguerite Pessagno emphasized a few distinguishing features. First, it is affordable to the clients when compared to traditional boarding home residences, which keep all but $25 of their clients' money. Second, there is strong interagency cooperation, particularly among Women of Hope, the Hall Mercer CMHC, and the Philadelphia Health Management Corporation, assuring quality and flexible care suited to the needs of residents. Third, they emphasize the role of client participation and empowerment. Clients play an essential role in the structuring of the program and its day-to-day operations. And fourth, the program allows for failure. Some women who have left the program and attempted to live independently have not been successful, and some have even returned to the streets. In such cases, the women are allowed to return to Women of Hope and begin the process again. This is not viewed as a negative outcome, but is accepted as part of the ongoing struggle of people with mental disabilities to gain greater control over their life circumstances.

Outcomes by Client Status

Between March 1985 and February 1991, 120 women had been residents at Women of Hope. As of 1991, the average age of the residents and former residents is 52, with approximately half of the women being below the age of 50 (52%), and half of the women being 50 years of age or older (48%). A significant group in the "over 70" age range (n = 12) pushes the mean slightly higher than the median. Fifty-nine percent of the women are black, and 40% are white. Approximately 38% of the women have had previous stays in a state hospital, 37% have had no such previous stays, and there was no information on 26% of the women. All of the women have spent considerable time living on the streets, with the average length of time homeless being 4.5 years. (This compares with point-in-time assessments of "length of time homeless" among the general homeless population in Philadelphia that have found 50% of the population as homeless for less than 6 months; see Ryan, Bartelt, & Goldstein, 1989). Women's length of stay in the Women of Hope program has ranged from a couple weeks to 5 years, with the average length of stay being 1.5 years.

Current Women of Hope residents account for approximately 41% of the total 120 women served, with 26 women currently in the original residence, and another 23 in the new residence. Occupancy has been at greater than 100% since the program's first year of operation.

Of the total 120 women served, 71 persons, or 59%, are no longer in either of the community residences. Table 1 shows the distribution of former residents by current status. According to client records maintained by the staff, all but two of the former residents (2.8%) can be accounted

for, with another seven women being deceased (9.9%). Otherwise, the former residents are in a wide range of residential circumstances, reflecting the diverse and individualized needs of the population. The majority, 73.2%, are not homeless and do not live on the streets. However, a significant 14.1% did return to the streets, representing 10 persons. Several of these women are new clients who have yet to stabilize within the Women of Hope program, and others continue to return to Women of Hope intermittently. All of the former residents living on the street are visited regularly by outreach workers.

Table 1

Disposition of Former Women of Hope Residents as of February, 1991, Based on Staff Tracking

	N	%
Independent Living		
Subsidized Apartments	19	26.8
SROs	5	7
With Family Members	5	7
YWCA	1	1.4
Sub-Total	30	42.2
Moderately Structured Residences		
Boarding Homes	4	5.6
Community Residential Rehabilitation	2	2.8
Low Demand Residence	2	2.8
Drug Rehabilitation	1	1.4
Sub-Total	9	12.6
Highly Structured Residences		
Skilled Care Facilities	7	9.9
Nursing Homes	4	5.6
State Hospital	2	2.8
Sub-Total	13	18.3
Other		
Streets	10	14.1
Deceased	7	9.9
Unknown	2	2.8
Sub-Total	19	26.8
Grand Total	71	99.9

Among the 73.2% of former residents who are "housed" (living, not on the streets, and whereabouts known), the majority, 42.2%, are in independent living situations, primarily in subsidized apartments (26.8%), secondarily in SRO's (7%) or with family members (7%), and with one person living in a YWCA (1.4%). The remaining 31% are in collective living arrangements with varying levels of support and supervision. Considering the most restrictive settings, there are 9.9% in skilled care facilities, 2.8% in the state hospital, and 5.6% in nursing homes, for a total of 18.3%. Other less restrictive placements include 5.6% in boarding homes, 2.8% in community residential rehabilitation programs, 1.4% in drug rehabilitation, and 2.8% in another "low demand residence."

The outcomes of former residents suggest that many solutions are needed to intervene successfully in the homelessness of women with serious mental illness. No one alternative has worked for everyone, although, generally speaking, clients have shown a preference for "normalized, independent living," with some support services. However, independent living has not been appropriate for all of the Women of Hope clients, with some significant subgroups needing highly structured and moderately structured residences. Finally, some of the clients have shown a preference for living at Women of Hope, and those preferences have also been accommodated in the program. Such persons are not reflected in the outcome data of former residents because they are still current residents. But the qualification should be noted, as the expectation that all persons will accept other housing may be inappropriate. What was conceived as a short-term respite from the streets may in fact meet some persons' expectations and needs for appropriate housing.

In conclusion, some mention should be made of the cost of Women of Hope's program. The services provided at Women of Hope had an annual cost of approximately $835,000 in 1991. With an average daily census of 49 people, the annual cost per person was $17,052. Since clients contribute $98,000 annually in rental income toward that cost, the adjusted yearly cost is $15,052 per client. The majority of funds for the operation of Women of Hope come from the state through the City of Philadelphia's Office of Mental Health (87%). Resident rental contributions account for 12% of the annual operating budget, and the United Way contributes 1% toward the program. The annual per-person cost of Women of Hope is considerably more than the City's shelter system, which spends approximately $5,500 per shelter bed annually (calculated from Office of Services to the Homeless and Adults' 1991 budget, excluding prevention and transitional service programs; personal communication). However, most shelters provide a minimal level of services for that cost, mandated to provide only food and a shelter cot that is 18 inches from the adjacent cot.

Considered from another perspective, the daily cost per person of Women of Hope ($46.71) is considerably less than the average daily cost of psychiatric hospitalization. Medicaid rates for psychiatric hospitalization average approximately $300 per bed day in Philadelphia, which on an annual basis is $109,500 per bed. Assuming an average length of stay of 28 days, a typical episode of hospitalization would cost around $8,400, or half of the annual cost of services at Women of Hope.

Discussion

The program at Women of Hope, and others like it (Blankertz, Cnaan, & Saunders, in press; Lipton, Nutt, & Sabatini, 1988), demonstrate that people with mental illness who are homeless can be helped in ending their homelessness. Even street people, who are often characterized as the most "resistant" and "noncompliant," can benefit from innovative programs that provide comprehensive services and that show sensitivity to the perspectives of the homeless. Conducting aggressive outreach, providing transitional housing that places few restrictions and regulations on people, encouraging and making available health and mental health services, supporting the perspectives and demands of clients, providing opportunities for vocational training and income eligibility, and making available supported housing alternatives, can combine to provide people with the resources they need to avoid living on the streets. In addition, program flexibility, ongoing consumer input, and an acceptance of failure are essential to the design of a truly responsive service system. A lack of such programming has been a significant factor in the development of homelessness among people with mental illness in the past, and the effective planning of such programs will be necessary to prevent homelessness in the future.

"Comprehensive services" for homeless people with mental illness require more resources than the existing emergency shelter system, but cost considerably less than the recurrent hospitalizations that might otherwise be necessary if such services are not provided. This cost differential has undoubtedly played a role in the shift from a hospital- to a community-based system of care, but supporters of a community-based system of mental health services surely had more in mind than emergency shelter programs for the homeless. Given the reality of costly hospitalizations and the human and social costs of destitution, a choice must be made to provide comprehensive community services, recognizing both the resources and political will necessary to achieve their adequate provision. Homelessness prevention programs should note the range of services and housing options which have been necessary to end homelessness among women with mental illness in Philadelphia, as such services will undoubtedly benefit those at risk of becoming homeless.

This paper is limited in that it is descriptive and did not systematically compare the Women of Hope program with another program for people with mental illness who are homeless. However, considered with other evidence and research summaries (Levine, 1990; Blankertz, Cnaan, & Saunders, in press; Lipton, Nutt, & Sabatini, 1988), there is an emerging consensus as to what must be done to have an impact on the homelessness of the mentally ill. Future research should attempt to determine what housing options work best for what groups of homeless people who have mental illness. Moreover, research should monitor the effectiveness of various housing programs and support services over time. The fact that the LDR could function as an actual housing program should also be considered, although more research is necessary to determine if this housing standard is sufficient over time and whether people with mental illness might have other housing aspirations if given the opportunity. This study is also limited in that it did not address the much larger problem of homelessness among people residing in emergency shelters. It is likely that other programs and approaches are necessary to address the needs of this larger and more diverse group of people, and that programs based on serving street people with severe mental illness will not have generalizable effects for the homeless population in shelters.

The author gratefully acknowledges the assistance of Srs. Mary Scullion and Maguerite Pessagno, RSM, for their contributions to this article.

REFERENCES

Ball, F. J., & Havassey, B. E. (1984). A survey of the problems and needs of homeless consumers of acute psychiatric services. *Hospital and Community Psychiatry, 35*, 917–921.

Blankertz, L. E., Cnaan, R. A., & Saunders, M. (in press). Assessing the impact of serving the long-term mentally disabled homeless. *Journal of Sociology and Social Welfare.*

Dattalo, P. (1990). Widening the range of services for the homeless mentally ill. *Administration and Policy in Mental Health, 17*(4), 247–256.

Ferrick, T., & Odom, M. (1989). A new breed of street people. *Philadelphia Inquirer, November 26*, A1.

First, R. J., Rife, J. C., & Kraus, S. (1990). Case management with people who are homeless and mentally ill: Preliminary findings from an NIMH demonstration project. *Psychosocial Rehabilitation Journal, 14*(2), 87–91.

Goering, P., Durbin, J., Trainor, J., & Paduchak, D. (1990). Developing housing for the homeless. *Psychosocial Rehabilitation Journal, 13*(4), 33–42.

Hagen, J. L., & Hutchinson, E. (1988). Who's serving the homeless? *Social Casework, 69*, 491–497.

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

Morrissey, J. P., & Dennis, D. L. (1990). *Homelessness and mental illness: Toward the next generation of research studies. Proceedings of an NIMH-sponsored conference.* Rockville, MD: National Institute of Mental Health.

Office of Services to the Homeless and Adults (1990). *City of Philadelphia's Homeless Assistance Plan, July 1990.* Philadelphia: Author.

Office of Services to the Homeless and Adults (1991). *Fiscal Year 1991 Operating Budget Testimony Presented to City Council of Philadelphia, April 22, 1991.* Philadelphia: Author.

Pollio, D. (1990). The street person: An integrated service provision model. *Psychosocial Rehabilitation Journal, 14*(2), 57–68.

Rog, D. J. (1988). *Engaging homeless persons with mental illness into treatment.* Rockville, MD: National Institute of Mental Health.

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

Ryan, P., Bartelt, D., & Goldstein, I. (1989). *Homelessness in Pennsylvania: How can this be?* Philadelphia: Coalition on Homelessness in Pennsylvania, and the Institute for Public Policy Studies at Temple University.