“Project HOPE” for Homeless Individuals with Co-Occurring Mental and Substance Abuse Disorders: Reducing Symptoms, Victimization, and Violence

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One of the most significant social issues in the United States is homelessness, with approximately 3.5 million people experiencing homelessness in a given year (National Coalition for the Homeless, 2005). A large and increasing proportion of these people (25-33%) experience serious mental disorders (Fischer & Breakey, 1991; North, Eyrich, Pollio, & Spitznagel, 2004; Sullivan, Burnham, Koegel, & Hollenberg, 2000), which typically are compounded by substance abuse disorders (Fischer & Breakey, 1991). Homeless individuals with co-occurring mental and substance abuse disorders are “an especially difficult population to treat, because their problems are numerous and severe” (Gonzalez & Rosenheck, 2002, p. 437). These individuals are at risk for victimization and violence, frequently cycle between the streets, jails, emergency rooms, and hospitals, and rarely show improvement in their symptoms or functioning (Kushel, Hahn, Evans, Bangsberg, & Moss, 2005; McNiel & Binder, 2005; Substance Abuse and Mental Health Services Administration, 2003).

Developing programs and policies to improve clinical and legal outcomes for this at-risk population has become a national priority (President’s New Freedom Commission on Mental Health, 2002). Although a variety of treatment programs have been developed for homeless individuals with dual diagnoses, two main treatment models have emerged: an intensive treatment or “linear residential” model and a more progressive, “Housing First” model (Tsemberis, Gulcur, & Nakae, 2004). Controversy has arisen about which model should be applied.

In Southern Nevada, where the present study was conducted, this controversy looms large. Las Vegas has been labeled the “Meanest City for the Homeless,” based in part on its criminalization of life-sustaining activities for homeless individuals (e.g., begging, sleeping, vagrancy) (National Coalition for the Homeless, 2002). In their first regional plan to help the nearly 8,000 homeless individuals in Southern Nevada, local governments adopted an intensive treatment model, which involves case management and (mandatory)
psychiatric and substance abuse treatment (Pratt, 2005). Critics argue that this plan will fail and point to the success of the alternative, progressive model that focuses on the chronically mentally ill, provides housing as soon as possible, and offers, but does not require, treatment and other services. Las Vegas’ Mayor asserts that the latter model is a “fairy tale:” without mandated, residential or inpatient psychiatric treatment, he believes, this population cannot be helped (Pratt, 2005).

In the present study, we evaluate a forerunner of the proposed intensive treatment model that was implemented and evaluated as a demonstration program two years ago. Although this evaluation was uncontrolled, the intensive treatment model’s process and outcomes are informative as part of the small literature policymakers can consult when selecting an approach for homeless individuals with co-occurring disorders. After summarizing the two main alternative approaches for this population, we present the aims of the present study.

**Alternative Approaches to Homelessness and Mental Illness**

The “Housing First” model provides clients with immediate housing that is not contingent upon treatment participation (Tsberis, Guleur, & Nakae, 2004). The program is designed to meet clients’ basic needs and increase social skills and job opportunities (Tsberis & Eisenberg, 2000). After clients obtain housing, they are required only to meet with the staff at least two times per month and have a money management plan. Treatment is offered, but not required. Studies of the Housing First model suggest that positive results are not a fairy tale. Quasi-experimental comparisons indicate that the Housing First model results in significantly higher retention rates than the intensive treatment model (Tsberis & Eisenberg, 2000; Tsberis, Moran, Shinn, Asmussen, & Shern, 2003). An experimental comparison of these models indicates that clients in Housing First were housed earlier, remained stably housed longer, and reported higher perceived choice than clients in the intensive treatment model (Tsberis et al., 2004). Moreover, there were no differences between groups in decreased psychiatric symptoms and substance abuse over the 2-year follow-up.

In contrast with the Housing First model, the intensive treatment model explicitly makes a client’s housing contingent upon treatment participation and progress. Care is prioritized, and housing is placed at the end of a treatment continuum. The individual first resides in group housing and earns privileges for substance abstinence and treatment compliance. Based on improvements in functioning, they may eventually move to independent housing. This model assumes that treatment is necessary to stabilize clients and ready them for permanent housing.

There are few studies of intensive treatment programs for homeless individuals with dual diagnoses, and only a handful of these are controlled. The only experimental study indicates that intensive treatment (residential or outpatient) is associated with few benefits, relative to outpatient “treatment as usual” (Burnam, Morton, McGlynn, & Petersen, 1995). Two quasi-experimental studies focus on intensive programs that are “integrated,” in that the same program provides both mental health and substance abuse services. The results indicate that integrated treatment may be modestly superior to non-integrated or traditional residential treatment (Drake, Yovetich, Bebout, & Harris, 1997; Kasprrov, Rosenheck, Frisman, & DiLella, 1999). A large observational study of homeless individuals with dual diagnoses ($n = 2,183$) indicates that the intensity of substance abuse treatment is positively associated with symptom improvement and negatively associated with incarceration (Gonzales & Rosenheck, 2002). Aside from these few remarkable studies, the sparse literature on this population indicates that the intensive treatment model is associated with treatment engagement difficulties and low rates of program retention (e.g., Orwin, Garrison-Mogren, Jacobs, & Sonnefeld, 1999; SAMHSA, 2003; Tsberis & Eisenberg, 2000).

**The Present Study: Evaluating an Intensive Treatment Model**

The Las Vegas “Homelessness Outreach Pilot Evaluation” (Project HOPE) evaluated in the present investigation is consistent with the intensive and integrated treatment approach to homeless individuals with co-occurring disorders. The staff consisted of two teams of three professionals (outreach, mental health, and substance abuse counselors) who
provided case management services to these individuals, including linkage with substance abuse and psychiatric treatment and social supports such as housing. An integral component of the program’s philosophy was gradual outreach, or identifying members of the target population and engaging them in services by helping immediately with basic problems (e.g., hunger). The project’s goal was to successfully engage 100 homeless individuals with co-occurring substance use disorders and mental illness in treatment, reduce their substance use and mental health symptoms, and to improve overall functioning (i.e., housing, employment, violence/victimization, and relationship status).

The present study evaluates Project HOPE’s: 1) process, or success in identifying clients, engaging them in treatment, and delivering services to them, and 2) outcomes, or effectiveness in reducing clients’ substance abuse, and improving their mental health and general functioning. We specifically assess whether involvement in intensive treatment reduces clients’ risk of victimization, violence, and arrest, as these are policy-relevant problems that disproportionately affect those with co-occurring disorders (e.g., Monahan et al., 2001; Sells, Rowe, Fisk, & Davidson, 2003); who are homeless (e.g., Padgett & Struening, 1992; Wenzel, Koegel, & Gelberg, 2000). This study is the first to report treatment-related changes in violence and victimization among homeless individuals with co-occurring disorders.

METHOD

Procedure

In Project HOPE, clients moved through up to four stages of treatment. In the Precontact stage, staff identified prospective clients attempted a nonintrusive greeting with them. Pre-contact interventions were designed to be non-threatening and helpful to the identified recipient (e.g., offering food, bus tokens, or assistance). Precontacts often were repeated before individuals advanced to the second stage. In the Contact stage, staff obtained personal information from clients (e.g., name, social security number) and determined whether they met the program’s eligibility criteria, which were: (1) homelessness (lacking “a fixed, regular, and adequate nighttime residence” or having “a primary nighttime residence that is a…shelter…an institution…or a…place not designed for…regular sleeping accommodation for human beings;” (General Definition of Homeless Individual, 2005), (2) a documented or observable substance abuse and mental health disorder, (3) capable of participating in treatment (e.g., can provide informed consent), and (4) does not pose a danger to self or others that requires a staff secured facility. Eligible contacts became Clients if and when they accepted treatment.

Clients began Project HOPE by completing either detoxification or assessment at a crisis triage center. They were then followed over time and linked with appropriate social services. Clients’ average length of treatment was nearly three months (M = 84 days, SD = 69). Clients became Completers if they stayed in treatment at least three months or until the end of the six-month HOPE project (whichever was shorter). Otherwise, clients were classified as Noncompleters because they dropped out of, failed to complete, withdrew from, or were dismissed from, treatment. The duration of noncompleters’ treatment was defined as the date of enrollment until the date they were coded as “inactive” (typically, the first day on which staff could not locate them).

Staff used laptop computers and electronic daily logs to record information about individuals in the precontact (appearance, location, referral source) and contact (demographics; eligibility) stages. They also recorded the dates and types of services (for billing), which were used to track individuals’ progress. Staff and/or a master’s level research assistant assessed clients’ symptoms, functioning, and violence/victimization at both (a) the time of admission (or completion of detoxification), and (b) the last month of treatment or end of Project HOPE, whichever came first.

Measures

Electronic records generated by staff were used to measure such process variables as the length of outreach process (time between initial contact and initial assessment), treatment refusals (number of eligible contacts who chose not become clients), treatment drop-outs (number of clients who
discontinued treatment after CTC assessment), and service delivery. Standardized measures were used to assess participants’ symptoms and functioning.

**Symptoms**

The Psychiatric Diagnostic Screening Questionnaire (PDSQ; Zimmerman & Mattia, 1999) was used to assess participants’ level of distress and Axis I diagnoses of mental and substance abuse disorders. This 126-item self-report inventory assesses for 13 relatively common DSM-IV disorders: major depressive disorder, posttraumatic stress disorder, bulimia/binge-eating disorder, obsessive-compulsive disorder, panic disorder, psychosis, agoraphobia, social phobia, alcohol abuse/dependence, drug abuse/dependence, generalized anxiety disorder, somatization disorder, and hypochondriasis. Its scales generally have good levels of internal consistency and high levels of discriminant and convergent validity.

The Substance Abuse Subtle Screening Inventory-3 (SASSI; Miller, Roberts, Brooks, & Lazowski, 1997) was used to screen for substance abuse and dependence. This 93-item self-report inventory generates scores on 10 scales, including a decision rule for substance dependence that has positive and negative predictive power of .94 and .93, respectively (Miller et al., 1997).

The Addiction Severity Index (ASI; McClellan et al., 1992) also was used to capture participants’ alcohol and drug use and abuse. This semi-structured interview provides information on recent (past month) and lifetime substance abuse and associated problems (e.g., medical, employment, family/social, legal, and psychiatric). The “lifetime” portion of the instrument was administered only at baseline. Given evidence that ASI composite scores can be problematic (Mäkälä, 2004), the present study draws upon individual ASI variables most relevant to tapping particular areas of change. The variables of focus for alcohol and drug use included (a) the recent number of days (out of 30 days) that the participant drank alcohol to intoxication, was bothered by alcohol problems, and was bothered by drug problems, and (b) how troubled the participant had been recently by alcohol problems, and by drug problems (on a scale ranging from 0, not at all to 5, extremely). Additional portions of the ASI were used to code changes in functioning.

**Functioning**

There were three primary sources of data about clients’ functioning: life calendars, the ASI, and domain-specific scales (e.g., for violence). The ASI was described earlier, and domain-specific scales are described later. The central measure used to describe functioning was a life event calendar (based on Horney, 2000), which captured clients’ problems during the three months prior to, and three months after, enrollment in Project HOPE. Although this technique is subject to many of the same problems as other retrospective methods (e.g., recall error), it has many advantages over simple surveys, including aided memory recall and improved interview quality (e.g., Axinn, Barber, & Gheimire, 1997; Belli, Shay, & Stafford, 2001; Caspi, Moffitt, Thornton, & Freedman, 1996; Freedman, Thornton, Camburn, Alwin, & Young-DeMarco, 1988; Horney & Marshall, 1991; Suchman & Jordan, 1990).

Clients viewed a calendar covering the relevant three month period and spent time anchoring recall by placing holidays, important personal dates (e.g., birthdays), and events on the calendar. Then, clients were asked to help interviews construct a timeline of their residence (where they were living), employment (whether they were working), and outpatient treatment (where they were receiving mental health and/or substance abuse treatment). Then, they recalled significant events that occurred during the recall period (e.g., emergency room visits). For each event, the date, type, and duration were recorded.

**Housing.** Participants’ residence timelines from their three-month life calendars were used to compute the number of days they spent in each of 10 housing statuses drawn from SAMSHA’s (2005) annual reports: outdoors, short term shelter, hotel/SRO/boarding house, institution/psychiatric hospital, jail/correctional facility, friend/family private residence, long term shelter, halfway house/residential program, rent/own, and other. These data were also used to indicate participants’ housing status at the end of the project.

**Employment.** Participants’ employment timelines for their three-month life calendars were used to compute the number of days they spent in full-time, part-time, or day work, and their employment status at the end of the project. ASI data were used to indicate how troubled participants’ were by their
employment problems (from 0, not at all to 5, extremely) in the month pre-treatment and at the end of treatment.

Entitlements, emergency services, and medical status. ASI data were used to indicate whether or not participants were receiving disability income for medical or psychiatric problems. Life calendar data were used to record emergency room visits, as well as hospital admissions and detoxifications. ASI data were used to indicate how troubled participants were (0, not at all to 5, extremely) by their medical problems pre-treatment and post-treatment.

Violence, victimization & arrests. Violence and victimization were assessed using an approach used in earlier research (Lidz, Mulvey, & Gardner, 1993; Monahan et al., 2001). In this approach, the interviewer asked patients and collateral informants at each interview whether the participant had engaged in any of eight categories of aggressive behavior (e.g., kicking, hitting) in the past two months. When respondents endorsed an aggressive behavior, they were asked to report the number of times the behavior occurred and to describe the incidents. If multiple aggressive acts were associated with a particular incident, only the most serious act that occurred during the incident was coded.

From these data, two mutually exclusive categories of violence were coded. Serious violence was defined as battery that resulted in physical injury (ranging from bruises to death), sexual assaults, assaultive acts that involved the use of a weapon, or threats made with a weapon in hand. Minor violence was defined as all other aggressive acts. A third variable, any violence, was computed by summing serious and minor violence. Similar definitions were used for victimization, with the difference being that the participant was the target rather than perpetrator of aggression. This study’s violence and victimization variables reflect whether or not a participant committed an act of violence (serious or any) or was victimized (serious or any) during each two-month recall period.

Life calendars were used to record police contacts, arrests, and jail bookings the three months before, and last three months during, treatment in Project HOPE. ASI data were used to indicate “how troubled” participants were by legal problems prior to, and at the end of, treatment.

Relationship status. Diminished social supports are a particular problem for homeless individuals (SAMHSA, 2003). Thus, Hendrick’s (1988) Relationship Assessment Scale (RAS) was administered at baseline and follow-up to assess the quality of the participant’s relationships with friends and family members over the past three months. The RAS is a 7-item general scale with strong internal consistency and convergent validity (e.g., Vaughn & Baier, 1999). ASI data were used to indicate how troubled participants were (0, not at all to 5, extremely) by their family problems and social problems pre-treatment and post-treatment.

RESULTS

Process

Outreach & Engagement

The majority (60%) of Project HOPE contacts were not the result of staff’s outreach efforts, but instead were referrals from substance abuse, medical, and mental health agencies that provided emergency or acute care. Staff were successful in identifying and enrolling clients, but less so at maintaining clients in treatment. Project HOPE staff recorded 236 Precontacts, 150 Contacts, 69 Clients, and 26 Completers. Two points are noteworthy. First, although the majority (64%) of Precontacts advanced to the Contact stage, 86 individuals did not advance. Although many prospective clients responded favorably to Precontact interventions, these small, sometimes repeated inducements were insufficient to sway some individuals into accepting further services or treatment.

Second, most (70%) eligible Contacts became Clients, but the majority (62%) of Clients failed to complete treatment. Of these Noncompleters, 67% were lost by staff (typically, when clients left a temporary residence or treatment facility), 24% withdrew from treatment, 5% were dismissed by staff, and 2% died. In the remainder of this report, we focus on the 69 Project HOPE Clients and 26 project Completers.
Consistency of Client Characteristics With Eligibility Criteria

Project HOPE successfully enrolled a multi-problem, high risk Client sample. On average, Clients were 38 years old (SD = 9), with a 12th grade educational attainment (SD = 2). The majority were male (67%) and Caucasian (75%; African American, 23%; Other, 2%). At baseline, the majority were living in short-term shelters (30%) or outdoors (25%), with the remainder at hotels, motels, or boarding houses (10%), halfway houses (9%), institutions (7%), in family/friends’ residences (7%), or “other” temporary places (7%). A minority (7%) were living in long-term shelters (3%). Of enrolled Clients, 38% had just spent over 3 months outdoors, 19% had spent 1-3 months outdoors, and 36% had spent 1 month or less outdoors. Three-quarters of Clients had been unemployed for 3 months prior to program entry.

On the PDSQ, Clients obtained an average Total T Score of 62 (SD =11), which indicates an “unusually high level of symptom endorsement relative to…clinical outpatients” (Zimmerman, 2002, p. 11). Clients’ average subscale scores exceeded the recommended PDSQ cutoff scores by at least one point for 6 of 13 disorders: major depressive disorder, posttraumatic stress disorder, generalized anxiety disorder, psychosis, alcohol abuse/dependence, and drug abuse/dependence. On the SASSI, 100% of Clients surpassed at least one decision rule indicating a “high probability” of a substance disorder, and fell above the normative sample’s 99th percentile for alcohol abuse (M = 23, SD = 11; t = 87), drug abuse (M = 27, SD = 11; t = 90), and symptoms associated with substance dependence (M = 9, SD = 2; t = 79).

ASI data indicate that, prior to enrollment, 7% and 9% of Clients were on disability for medical and psychiatric problems, respectively. Life calendar data indicate that, during the three months prior to becoming a Project HOPE Client, 42% had visited a detoxification unit, 31% had visited the ER, 24% had been medically or psychiatrically hospitalized, 13% had contact with the police, and 8% were arrested. During the two months prior to becoming a Project HOPE Client, almost half had been violent (47% any violence; 10% serious violence) and victimized (47% any victimization; 24% serious victimization). Women (60% vs. 9% men), \( X^2 (1, N = 50) = 15.2, p < .001 \), and individuals with more severe mental health symptoms (PDSQ Total, \( r = .29, p = .04 \)) were more likely to be seriously victimized.

Service Delivery

During their average three month period in Project HOPE, nearly one-third of Clients (30%, including 4% of Completers and 50% of Non-completers) received no recorded services. The remaining Clients often received services within two weeks of enrolling in the program (M = 12 days, SD = 21 days).

For Clients who received at least one service, the average number of service hours received was computed for each service type. Clients received an average of 42 (SD = 36) service hours during their average 84 day stay in the HOPE project. Completers and Noncompleters received averages of 53 (SD = 44) and 29 (SD = 19) service hours during their average 144 or 40 day stays, respectively.

Figure 1 depicts the average number of hours of different types of direct services that Clients received. Services focused on diagnostic testing and treatment planning, meeting basic needs (e.g., food), and substance abuse service coordination or counseling. There was less emphasis on housing and mental health service coordination or counseling. As shown later, there were virtually no significant differences between Completers and Noncompleters in the rate of services they received across the 12 types of services presented in Figure 1.

Outcome

Although staff successfully identified and enrolled a highly at risk sample, there were problems with Client retention and relatively little delivery of services that addressed housing and mental health needs. The next logical question is whether the services Clients did receive (focused on assessment, basic needs, and substance abuse) helped them. To address this question, we focus on the subset of Clients who completed Project HOPE.

Comparing Completers and Noncompleters

To indicate which Clients are (and are not) represented by our results, it is important to first
describe the differences between treatment “Completers” \((n = 26)\) and “Noncompleters” \((n = 43)\). Given the limited sample size and our wish to detect any differences between these groups, we applied a liberal significance level \((p < .10)\), which yielded approximately 75% power to detect a medium effect (Cohen, 1992). At baseline, there were no significant differences between groups in gender, ethnicity, age, educational attainment, level of psychiatric (PDSQ) or substance abuse (SASSI) symptoms, or involvement in violence or victimization. Relative to Noncompleters, however, Completers were more likely to have spent significant time outdoors at baseline (<1 month, 28% vs. 46%; 1-2.9 months, 36% vs. 10%; ≥ 3 months outdoors, 35% vs. 44%, \(X^2 (2, N = 64) = 6.5, p = .04\)).

A comparison of the two groups’ rates (i.e., hours of service/days in program) of service across the 12 service types listed in Figure 1 indicated only one significant difference \((p < .01\), given 12 comparisons). Completers received less psychiatric service coordination than Noncompleters \((M = .01, .10 SD = .02, .15\), respectively) \(t (46) = 2.3, p = .01\).

In summary, Completers were comparable to Noncompleters in their demographic characteristics and psychiatric and substance abuse symptoms, but were somewhat more chronically homeless and received a lower rate of psychiatric services during the project.

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1 Basic Needs= assist in accessing food, clothing, transportation, etc; Treatment Planning = assess and plan treatment strategies with client, team, and/or community provider; Substance Abuse = linking with community substance abuse services and providing direct counseling; Housing = linking with community housing services; Diagnostic testing= administration of standardized tools for assessment; Medical = linking with community medical services; Psychiatric = linking with community psychiatric services; Crisis Intervention = intervening to assist in resolving immediate problem; Employment = linking with community employment services; Referral = providing resource information to client. Other services provided an average of less than 1 hour include criminal justice system service coordination, provision of mental health counseling, and vocational service coordination.
**Improvement in Functioning**

The remainder of the results focuses on Completers, comparing their functioning prior to treatment with that at the end of treatment. The average length of time between assessment periods was three months ($M = 90$ days, $SD = 15$). Our limited sample size ($n = 52$, or 26 Completers with two time points) raises two important issues. First, it is important to note that few data were missing: the modal number of missing values is 0 and no variables are missing more than 5% of cases. Because the data may not be missing at random, pairwise deletion was applied. Second, a liberal alpha level ($p < .10$) was used for these comparisons, providing an estimated 80% power to detect a large effect. To assess the potential impact of limited power on our results, we repeated several of the analyses described below with the 39 HOPE clients who completed two or more months of treatment (rather than three). A similar pattern of results was obtained, suggesting that the effects reported here for Completers are reliable. The chief measures used in this section are the Life Calendar (with recall periods the three months before treatment and the three months during treatment), violence and victimization assessment (with recall periods the two months before treatment and two months before treatment termination) and indices from the ASI (with recall periods 1 month before treatment and the last month before treatment termination).

**Housing.** Life calendar data indicate that Completers rented or owned their own residence for significantly more days after treatment (Pre = 4, $SD = 13$; Post = 19, $SD = 34$; $t [23] = 1.9, p = .07$) and spent significantly fewer days outdoors (Pre = 13, $SD = 27$; Post = 1, $SD = 5$; $t [23] = 6.2, p < .001$). Although defining “unstable” housing is a difficult enterprise, these two categories (renting/owning vs. living outdoors) may be viewed as extremes on that continuum. Table 1 provides a fuller descriptive picture, which indicates that, of Completers, over one-quarter were living outdoors before treatment, compared to none at the end of the program.

**Employment.** Life calendar data indicate no significant change in the number of days Completers were unemployed or engaged in day labor, in keeping with ASI data. Nevertheless, ASI data indicate that completers were significantly less troubled by employment problems at the end of treatment than they were before it began (Pre = 3.4, $SD = 1.3$; Post = 2.0, $SD = 1.7$, $t [19] = 3.2, p = .006$).

**Entitlements, emergency services, and medical status.** ASI data indicate no significant change in (a) the number of Completers who received a pension for psychiatric or physical disabilities, and (b) how troubled Completers were by their medical status prior to, and at the end of, treatment. Similarly, life calendar data indicate no significant change in the number of Completers’ ER admissions, detoxifications, or psychiatric or medical admissions prior to, and at the end of, treatment.

**Violence, victimization, & arrests.** Given the low base rate of serious victimization and violence, statistical significance tests focus on any victimization and any violence. Significantly more Completers were victimized during the two months before HOPE treatment (67%) than during the two months at the end of treatment (16%, McNemar $X^2$ test).
[1, N = 26] = .20, p = .09). Similarly, more Completers were violent prior to HOPE treatment (46%) than at the end of it (20%, McNemar X² [1, N = 25] = 3.0, p = .07). There were no significant differences in the number of police contacts or arrests the three months prior to, and at the end of, treatment. Similarly, ASI data indicated no significant differences in how troubled Completers felt about their legal problems the month prior to, and the month at the end of, treatment.

Relationships. RAS data indicate significant improvement in Completers’ overall relationship quality (Pre = 15.8, SD = 5.7; Post = 20.9, SD = 6.6, t[20] = -4.2, p < .001). Similarly, ASI data indicate that Completers were significantly less troubled by social (but not family) problems at the end of treatment (Pre = 1.91, SD = 1.9, Post = 1.00, SD = 1.7, t[22] = 1.9, p = .07).

Improvement in Psychiatric Symptoms and Substance Abuse

Project HOPE also was successful in reducing psychiatric and substance abuse symptoms. Completers demonstrated a reduction in overall mental health symptoms (PDSQ Total t score, Pre = 60.12, SD = 9.0, Post = 55.0, SD = 10.3, t[24] = 2.22, p = .04). At the PDSQ subscale level, there were significant reductions in major depression (Pre = 14.00, SD = 4.9, Post = 8.19, SD = 5.2, t[24] = 4.24, p < .001), generalized anxiety disorder (Pre = 8.36, SD = 1.9, Post = 7.16, SD = 3.2, t[24] = 2.17, p = .04), and psychotic disorders (Pre = 1.88, SD = 1.8, Post = 1.04, SD = 1.8, t[24] = 2.06, p = .05). ASI data also indicate that Completers were significantly less troubled by psychiatric problems at the end of Project HOPE than before they began treatment (Pre = 3.5, SD = 1.2; Post = 2.61, SD = 1.3, t[22] = 2.4, p = .04), but were still “Moderately to Considerably” troubled by these problems.

Although the PDSQ indicated no significant reductions in alcohol or drug dependence disorders, substance use and abuse can change more rapidly than overall dependence. ASI data indicate that, relative to the month before treatment, Completers showed a significant reduction in the number of days they drank alcohol to intoxication (Pre = 9.81, SD = 11.3, Post = 2.13, SD = 5.0, t[15] = 2.51, p = .02), had alcohol problems (Pre = 16.20, SD = 13.0, Post = 2.93, SD = 6.1, t[14] = 4.45, p = .001), and had drug problems (Pre = 16.73, SD = 12.9, Post = 2.80, SD = 4.6, t[14] = 4.70, p < .001) during the last month of treatment. ASI data also indicate that Completers were significantly less troubled by alcohol problems (Pre = 2.79, SD = 1.5, Post = 0.89, SD = 1.5, t[18] = 4.46, p < .001) and drug problems (Pre = 2.53, SD = 1.9, Post = 1.00, SD = 1.7, t[18] = 3.41, p = .003) by the end of treatment than they were before it began. By the end of treatment, completers were only “Slightly” troubled by substance abuse problems.

Outcome Summary

In summary, the outcome results indicate that Clients who completed Project HOPE showed significant improvement across several domains. Although treatment was not associated with decreases in unemployment, arrests, or use of emergency services, Completers’ housing because significantly more stable, their relationships improved, and they were less often violent and victimized by the end of treatment. Completers also manifested significant reductions in psychiatric symptoms (primarily depression) and substance use/abuse (primarily alcohol). Although causal attributions about these results cannot be drawn because this was not an experiment (there is no control group and clients were not randomized to conditions), these results are promising.

DISCUSSION

As an intensive treatment model, Project HOPE was designed to engage homeless individuals with co-occurring disorders in treatment quickly (process) and to reduce their substance use and improve their mental health and functioning (outcome). This study yielded three main findings. First, Project HOPE effectively identified a high risk population and enrolled them in treatment. At enrollment, the modal Client had spent over three months outdoors, had been recently violent and victimized, manifested pronounced substance abuse and psychiatric symptoms, and had recently required emergency or acute care. Second, the majority (62%) of Clients enrolled in Project HOPE discontinued treatment in less than three months. Clients who completed treatment were demographically and clinically similar to those who discontinued treatment, but were
more chronically homeless. Third, those who completed Project HOPE showed remarkable improvement across several domains. Relative to their state before entering treatment, these individuals had more stable housing, fewer incidents of violence and victimization, fewer psychiatric and substance abuse problems, and better relationships at the end of Project HOPE. After highlighting these findings, implications for future research for homeless individuals with co-occurring disorders will be presented.

Outreach: Enrolling a High Risk Population

As mentioned, Project HOPE was fairly successful in identifying and enrolling the target high risk group. In addition to unstable dwellings and pronounced symptoms, this group had remarkable rates of violence and victimization. During the two months prior to becoming a client, almost half had been violent (47% any violence; 10% serious violence) and victimized (47% any victimization; 24% serious victimization). In keeping with the results of Rosenheck and Lam (1997), we found that women and individuals with serious mental health symptoms were especially vulnerable to serious victimization. This is disconcerting, given that victimization predicts poorer housing and quality of life outcomes (Lam & Rosenheck, 1998).

Maintenance: Losing the Majority of Clients

In keeping with the results of past research (Blankertz & Cnaan, 1993; Orwin et al., 1999; Rahav, Nuttbrock, Rivera, & Mg-Mag, 1997), this intensive treatment program had poor rates of retention. Only 38% of Clients remained in the program for at least three months. Available data suggest that Clients discontinued Project HOPE based on their (a) transient living situations (67% were lost by staff when they left a temporary living environment), and/or (b) incomplete treatment engagement (24% formally withdrew from treatment). Project HOPE services focused on Client’s basic needs (e.g., food, clothing) and substance abuse; there was little emphasis on obtaining long term housing, which was dependent on treatment progress. If Project HOPE had focused more immediately on long term housing, staff may have been better able to track Clients and Clients may have been more willing to remain in treatment, given the tangible payoff.

In its blueprint for ending homelessness among those with co-occurring disorders, SAMHSA (2003) explicitly recommends that services become more client-centered. This will involve shifting service priorities. In contrast with service providers, homeless individuals rate obtaining long-term housing as their top priority (Rosenheck & Lam, 1997; see also Burt et al., 1999). As stated by Oakley and Dennis (1996), “shelter, sustenance, and security needs should be met before addressing an individual’s need for treatment.” There is evidence that providing services that clients feel are beneficial to them increases the length of their stay with a program. Relative to intensive treatment models, the “Housing First” model results in greater client retention, residential stability, and perceptions of choice and autonomy (Tsemberis et al., 2004; Tsemberis & Eisenberg, 2000). At the same time, there is no difference between the models’ effectiveness in reducing psychiatric and substance abuse symptoms (Tsemberis et al., 2004).

Outcomes: Clear Improvements in Key Domains

When clients remain in treatment, the intensive treatment model appears effective across several domains. Perhaps because of the relatively short follow-up period (i.e., an average of six months), Clients who completed Project HOPE manifested no changes in their legal status (including arrests; cf. Gonzales & Rosenheck, 2002), employment status, medical status, entitlements, or receipt of emergency services. Nevertheless, these clients manifested positive outcomes across four key dimensions: (a) reduced substance abuse and psychiatric symptoms, (b) improved relationship quality, which is key, given reduced social supports for this population (SAMHSA, 2003), (c) increased days of stable housing, and (d) decreased incidence of violence and victimization. The latter two findings are of particular note. Although Project HOPE embraced a “treatment first” model, it clearly resulted in positive housing outcomes. More than one-quarter (27%) of Completers were living outdoors prior to Project HOPE, compared to zero who remained outdoors at the end of treatment. Similarly, although no Completers were renting or living in their own residence at the beginning of treatment, one-quarter were by the end of treatment.
Moreover, Completers manifested remarkable decreases in violence and victimization. This study is the first to report treatment-related changes in violence and victimization among homeless individuals with co-occurring disorders. Victimization rates decreased from 67% to 16% before, and at the end of, treatment. Similarly, violence rates decreased from 46% to 20%. Given the importance of these outcomes, future research is needed to determine the mechanisms by which they were obtained. Ideally, treatment would focus on changeable risk factors for violence and victimization (Douglas & Skeem, 2005). It is likely that Project HOPE’s effect on violence and victimization was indirect. For example, involvement in the project may have resulted in more secure living environments that reduced the need or opportunity for aggression and self protection (see Fischer, 1992). Or, the project may have provided linkage with services that reduced substance use, which in turn decreased violence potential (see Steadman et al., 1998). Future longitudinal research is necessary to address this key issue, given the importance of basic physical safety and security to this at-risk group.

Unfortunately, this study included no control group and we are unable to follow clients who dropped out of treatment. Although it is possible that the positive outcomes observed here are artifacts of the more serious cases dropping out of treatment, this explanation seems unlikely. Compared with clients who dropped out of treatment, those who completed treatment were demographically similar, equally symptomatic, equally violent and victimized, and more chronically homeless. These high risk clients showed clinically significant, remarkable improvements.

Conclusions

Project HOPE was a demonstration project with a short lifespan (six months). It is likely that the clients who were maintained in Project HOPE would have continued to improve, if the program’s lifespan was extended. Available data indicates that treatment outcomes are better the longer a homeless dually diagnosed client remains in treatment (Rahav et al., 1997).

The question for policymakers is whether the ‘trophy is worth the game.’ In this intensive treatment program, significant resources were expended to leverage a high risk group of homeless individuals into treatment. Although staff attended to client’s basic needs, long-term housing was a secondary concern clearly linked with treatment progress. Perhaps as a result, the majority of clients disappeared or withdrew from treatment. Only 26 Clients were maintained in treatment for three months or more. Given that homeless individuals with co-occurring disorders in this project’s home city number in the thousands, policymakers may wish to revisit the available data to evaluate whether the “Housing First” approach is a fairytale. Accumulating evidence suggests that clients are substantially more likely to embrace this approach than the intensive treatment model. An approach that is capable of engaging a meaningful proportion of our most vulnerable citizens is worthy of consideration, particularly when the approach may deliver outcomes as positive as those observed here for the few that completed Project HOPE.

REFERENCES


Substance Abuse and Mental Health Services Administration (SAMHSA, 2005). Projects for the Assistance of Transition from Homelessness: PATH Data Tables for 2004,


