From despair to hope

A report by Rebecca Ann Proehl, Ph.D.
Collage created by an Anonymous client in dual diagnosis recovery program at St. Mary's Center.

Front Cover: "Mentally Ill and Homeless - Help Me" by Milas Hackett
Dear Friends,

This report “From Despair to Hope” is testament to the possibility of the human spirit. The California Endowment invested in St. Mary’s Center and opened up new worlds to homeless seniors who struggle with mental illness. We are so grateful for their confidence in our work and their concern for such a vulnerable population.

We are also grateful to Dr. Rebecca Proehl for her guidance and evaluation of the Coaching Elders program. Her patient mentoring in the methods of Social Action Research has enriched and strengthened St. Mary’s Center’s community.

St. Mary’s Center is a nonprofit organization dedicated to providing services and a voice for extremely low-income seniors. A few years ago, we were frustrated by our limitations in helping to stabilize the lives of seniors with mental illness. This report gives an overview of our program, a description of the holistic dual diagnosis program that evolved and an in-depth evaluation of the difference the interventions are making in the lives of seniors.

Today some of our strongest leaders in the organization are people helped by this program. They have become mentors for others and advocates on social issues. We have incorporated some of their oral histories, artwork, poetry and photographs into this report to give a feeling of how their lives have been enriched by this program.

Community organizations offer the safety net programs upon which the poor depend. We recognize that part of our responsibility is finding ways to share what we have learned so that others might relatively easily replicate such a program. May this guide help to facilitate the transformation from “Despair to Hope.”

Sincerely,

Carol Johnson, MSW
Executive Director
Homelessness is a frightening and dangerous existence for any individual in the urban environment, and senior citizens are the weakest prey. Homeless older adults are vulnerable to assault, robbery and rape. Most are afraid to stay in a shelter open to all ages. They suffer inside hidden doorways, under bridges and freeways. They vigilantly lie awake or walk all night long to avoid danger. Many need immediate medical attention for high risk health conditions and mental health problems. Homeless seniors suffer from malnutrition, dehydration and fatigue. Tragically, homeless elders are frequently in hospital emergency rooms or found dead on the streets.

The senior population is growing faster than any other age group in America.

INTRODUCTION

In the past thirty years, the age group over 65 grew by 74%. In the next thirty years this group will account for 20% of the total population, which is up from 13% in 2000 (American Association of Geriatric Psychiatrists, n.d.). At the same time the aging population is growing, the amount of affordable housing is decreasing, thus making the marginally housed even more vulnerable (Rosenheck, Bassuk, & Saloman, 1998).

Given the unique challenges of working with the elderly homeless with mental illness, it is important to examine programs that have successfully served this population.

The aim of this report is to:

I Provide an overview of a model program for the homeless elderly with mental health problems,

II Examine the results of an evaluation conducted at the agency, and,

III Discuss the lessons learned throughout the process.

It is said that you can judge a culture by how they care for their elders. This report provides a blueprint for communities wanting to serve this vulnerable population.

I was born in 1946 and raised in East Oakland. Last winter I was living in a motel. I'm on a fixed income. My check ran out in the middle of the month, and I didn't have any money. My son said, "Mama, I hate to tell you this, but I can't help you." I went to a couple of agencies and they gave me numbers to call. I called and called, and none of them answered. Then St. Mary's answered the phone. I was crying, "Please, please help me. I don't want to live in the streets! I ain't never lived in the streets in my life!"

They gave me a bed in the shelter that very night.

I was scared to death. I felt so low, and I cried all the time. I was too depressed to do anything for myself. Talking to the psychiatrist helped me with my depression, and I took medication for a little while until I calmed down. I also went to the non-violence class they had. We learned how to recognize and control our emotions, and how to talk to people nicely. I apply those things in my life.

I walk back and forth to St. Mary’s every day to visit with my friends now that I have my own place. Staff come out to the courtyard and visit with us. They don’t talk down to us like we’re nothing. St. Mary’s is just like a big old family! We all try to do everything for each other, if we can, and advocate for change.

~ Darlene Thomas
I - **Program Description**

St. Mary’s Center dwells in the heart of the community it serves in Oakland, California. Benches, tables, and trees in front of the center provide a welcoming place for clients. The Cesar Chavez Memorial Garden conveys to those who enter the courtyard that social justice values drive this organization. Much of the interaction between staff and clients takes place in the informal outdoor environment. This casual contact helps to forge trusting relationships between the two. The Center’s office is open, accessible, and welcoming with artwork created by the clients displayed throughout the facility. A dining room serves as a place for meals, a drop-in center, a nursing station, and an emergency shelter in the winter. In addition to the strong commitment to social justice, there is also a spiritual orientation in the organization, though not a specifically religious one. It is evident that staff members treat clients with respect and dignity, stemming from an underlying belief that “each person has infinite value and worth” (Fuhr, 1996, p. 5).

St. Mary’s Center has served extremely low income seniors since 1973, and may be the only independent nonprofit organization in the country that is a comprehensive umbrella organization specifically for homeless seniors. They serve people age 55 and over of all racial, cultural and religious backgrounds, of any sexual orientation. Their 33 staff members reflect the ethnic diversity of the clients. The client population is 45% African American, 35% Caucasian, 14% Asian/Pacific Islander, and 6% Latino/a. The agency also offers a preschool, providing daily educational enrichment to low income and homeless children.

**Services**

- Daily Meals
- Case Management
- Medical Health Screenings
- Peer Group Support and Cultural Celebrations
- Counseling by Licensed Mental Health Therapists/Licensed Clinical Social Workers
- Winter Shelter
- Financial Management
- Home Visits and Telephone Reassurance
- Recovery 55 Substance Abuse/Dual Diagnosis Program
- Senior Advocate For Hope and Justice
- Drop-in Center
- Outreach and Advocacy
- Psychiatric Evaluations and Follow-up Care
- Music, Art, Communication, Wellness & Meditation Groups

Historically, St. Mary’s Center reached out to isolated seniors to bring them together to share a meal. Their anchor program became a peer driven friendly visiting program, including telephone reassurance, and individual advocacy around entitlements such as Supplemental Security Income (SSI), medical care, transportation, and immigration. In 1988, case management for homeless seniors began. At that time it was possible to rent a room and have money to eat with a General Assistance (GA) check. With SSI, many seniors were able to rent market rate units. The 1989 Loma Prieta earthquake irreparably damaged many of the downtown hotels occupied by seniors. Thus began the crisis of senior homelessness.
We opened the Winter Shelter for seniors because we were not able to house seniors in permanent or temporary situations, and we couldn’t even find space for them in shelters. We turned our dining room into a makeshift shelter at night. Since then we have served about 100 unduplicated seniors (some eighty and ninety years old) each December through April. The Loma Prieta earthquake left many seniors homeless, and although we haven’t experienced any more earthquakes, the housing landscape continues to shift dramatically. The near elimination of single room occupancy (SRO) hotels in our city, and throughout the country, coupled with massive gentrification efforts, again, here and nationally, has destroyed thousands of the lowest cost housing units available. On top of that, thousands of what used to be Section 8 Senior apartment buildings have been lost as owners have opted out of their contract, and converted the buildings to market rate. Furthermore, HUD’s 2004 budget to assist low-income people with housing is one third of what it was in 1976.”

In the early 90’s, St. Mary’s Center began Recovery 55, a senior specific alcohol and drug outpatient recovery program. In 1998, the Center welcomed San Francisco State University nursing faculty and students, to provide year round geriatric community nursing services. In the same year, passionate about expanding services for homeless seniors, St. Mary’s Center opened an Emergency Winter Shelter with cots for 25 people.

Case managers at the Center estimated that approximately 70% of the homeless seniors served struggled with mental illness or co-occurring mental health and substance abuse disorders (dual diagnosis disorders). In 2002, St. Mary’s Center approached California Endowment for a grant to develop Coaching Elders; the Coaching Elders program was launched to add a mental health component with trained mental health practitioners. All programs were eventually integrated into a holistic system of interventions designed to better meet the overall needs of seniors with multiple diagnoses, including mental health, substance abuse, medical complications, and social service needs. The result was that clients were more easily housed, and able to better maintain housing due to better overall stability and follow up case management.

While the Center provides direct services for poor and homeless seniors, its goals are broader and more ambitious than pure service delivery. The philosophical foundation of the Center is to address the deeper social problems and economic structures that contribute to poverty, mental illness, and homelessness in the first place. In the spring of 2000, St. Mary’s Center hosted a community convening on Hunger and Homelessness in the Midst of Prosperity. Out of that event grew the Center’s Senior Advocates for Hope and Justice. Staff encourages seniors to find their voice and tell their stories, to effectively influence public policy. Seniors have offered strong and impacting testimony at all levels of government on issues of basic human dignity and rights. Advocates learn that being a citizen in today’s world requires much more than voting.
“I work with a myriad of social service agencies and hundreds of social workers daily. No agency has shown me such easy access and quick response with hundred percent positive results so that seniors can maintain independence. The Center’s unrelenting effort to reach out to those who are in abysmal life situations is unparalleled.”

CO-occurring Mental Health and Substance Abuse Problems

Some people bring their mental health problems and substance abuse behaviors with them as they age. For other individuals, dependence on alcohol, prescription drugs or illicit drug use may occur for the first time at older ages, unknowingly or in response to efforts to self-medicate emotional and/or physical pain.

The extent of co-morbid mental health and substance abuse problems in older adults is often underestimated. According to a 1998 estimate, “as many as 60% of older psychiatric inpatients have co-morbid substance use disorders, mainly alcohol, while half or more of older alcoholic patients suffer from one or more additional psychiatric disorders, and as many as 15% also suffer from abuse or dependence on prescribed psychoactive drugs.” (Atkinson,Turner, & Tolson, 1998).

“There are many predisposing factors in older adults that contribute to the high rate of co-morbidity. High risk factors include loss of loved ones, loss of vocation, status and independence, social isolation and loneliness, major financial problems, poverty, dislocation of habitat, homelessness, family conflict and estrangement, boredom, physiological changes affecting alcohol and drug effects, complex medical problems, use of multiple medications, sensory deficits, reduced mobility, cognitive impairment, impaired self-care, loss of appearance, reduced self-regard and social demoralization due to ageism.” (Blow, F.C., Consensus Panel Chair, 1998. Substance Abuse Among Older Adults. Rockville, MD: US Department of Health and Human Services, 76).

A study by Joseph Groerer of SAMHSA’s Office of Applied Studies published these conclusions: “The need for substance abuse treatment for older Americans is expected to nearly triple in 2020 as the baby boom carries its substance abuse into older ages. The study projects that the number of adults age 50 and older, who will need treatment for a substance abuse problem, will grow to 4.4 million in 2020, compared to 1.7 million in 2000 and 2001. Baby boomers and the post-baby-boom cohort (those Americans born between 1946 and 1970) have used alcohol and illicit drugs at higher rates than earlier birth cohorts and will as a result exhibit problematic drug and alcohol use at higher rates than their elders. In response to the magnitude of the problems projected, the authors call for an increased focus on the special needs of an older population of substance abusers.” (Groerer, Penne, Pemberton and Folsom, Research Triangle, 2002. Journal of Drug and Alcohol Dependence, March issue, 2003).

A Man’s Home Is His Castle
by Michael Creedon

It’s nice weather in here, but outside
It’s a blizzard. The homeless are stacked
In mounds outside my windows,
Insulating my apartment while
They freeze. It’s not my problem.

I have to keep my windows closed
To keep out the smell, but I don’t mind;
Into each life a little wind blows.
And maybe the answer was
Blowing in the wind back then,
But in here the answer is blowing
In the central heating during winter.
If homes are found for the homeless,
There goes my free insulation against the
Darker elements.

I am not afraid to go outside
And walk among them. The abused
Invite abuse. They deserve it.
The dirtier and wounded and
Stinkier and uglier and beat
They are, the more they are
Reveiled. Heap it on! my
Inner voice cries as I kick aside
A sick woman who is crawling
In the gutter for a piece of bread.
Get a job, bitch! That bread
Was meant for the pigeons. The winds
Blow like daggers out here.
It’s a relief to get back inside,
Where a man’s home is his castle.
“Community is the secret at St. Mary’s Center. People here are like family, both clients and staff. They don’t let you fall through the cracks. They have this holistic concept and each staff has their expertise.”

II - PROGRAM INTERVENTIONS

The Coaching Elders program focused on initiatives that went beyond providing direct services to clients. The program offered three different, though related, services for seniors at risk.

1. **Integrated Services**: Providing comprehensive mental health, substance abuse and support services for homeless elders;

2. **Empowerment**: Increasing the ability of homeless seniors to care for themselves and to advocate for change; and

3. **Destigmatization**: Decreasing the stigma attached to mental illness by educating seniors, community members, and policymakers about the myths of mental illness.

### INTEGRATED MENTAL HEALTH, SUBSTANCE ABUSE AND SUPPORT SERVICES

José, a 60-year-old Mexican American, has been clean and sober for 2 1/2 years. He participates in a holistic program at St. Mary’s Center for substance abuse recovery, mental health treatment, and advocacy for economic rights for poor people. Jose is pursuing an AA degree in social services and was recently recognized as one of thirty California Senior Volunteer Leaders by the University of California Berkeley, School of Public Health.

José wants to help seniors live healthy lives and says, “I received hope from St. Mary’s Center. I am learning to rely on myself to survive in a socially acceptable way. Sometimes I have interference inside me: my mind wanders. The backbone connects all the heads as one. I call the heads “My Committee.” The head on the left is not feeling good, the one on the right is mania, and in the middle is me. I always feel intensely, passionately alive. My nervous system, compounded with the imbalance of chemicals in my brain, makes me feel punchy. In my holistic treatment, I learn to manage my symptoms, to contain all this energy and to take better care of myself.”

~José Querdo

St. Mary’s Center developed the kind of program policy makers and researchers recommend for addressing the needs of this population. The researchers for the recently published document, entitled Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and Co-occurring Substance Use Disorders emphasized the importance of having aggressive outreach programs, providing intensive case management, and offering integrated treatment for co-occurring mental illness and substance abuse disorders (Wells, Williams, and Dennis, 2003). They accentuated the value of self-help programs that involve individuals who were formerly homeless in treating this population. This study concluded that these self-help programs are successful because they focus on choice, dignity, and respect — ingredients, which unfortunately are often missing in our service delivery systems (Glasser in Wells et al., 2003). All of these elements are present in the Coaching Elders program.
“Clients now raise issues around mental health in groups, and they are more comfortable with the topic. They are more understanding of fellow clients who display symptoms of mental illness, and they are even beginning to refer clients for counseling.”

Specifically the steps taken to develop the new mental health service included:

1. Hiring professionally trained mental health personnel, including a psychiatrist, a Licensed Clinical Social Worker and a Licensed Marriage Family Therapist, and referring clients who manifested major mental health disorders for in-house psychiatric evaluation, monitoring of medications, and mental health/dual diagnosis counseling.

2. Providing extensive training for case managers and outreach workers on mental health issues of the elderly, including assessment skills necessary to determine signs of mental illness and dual diagnoses among their clients.

3. Developing new intake tools for the program’s mental health clients and conducting thorough assessments for those clients.

4. Conducting weekly, multi-disciplinary case presentations in staff meetings to develop greater expertise in serving mentally ill and dually diagnosed clients.

5. Preparing comprehensive care plans with clients and monitoring the progress of the program’s clients by conducting case reviews.

6. Ensuring that mental health-related topics were presented twice a month in each of the various support groups at The Center.

7. Utilizing standardized mental health assessments and other measures to determine client progress.

8. Holding monthly training of all staff members within the Center on issues related to mental illness and dual diagnosis disorders. This ambitious undertaking was necessary so all support staff within the agency had a solid understanding of mental illness as well as sensitivity to the plight of the mentally ill.

After losing my job, I found myself in a place I never dreamed of ever being—homeless. Due to economic conditions, the large company I thought would provide me with financial security proved me wrong. I could not find work and had no nest egg available. My husband had died the prior year due to an illness, which had left him unable to work for years. Our financial resources were devoured, and we lost our home.

I ended up at St. Mary’s shelter in Oakland. There my most in-depth education and expanding awareness in the field of humanity unfolded. I met people from all walks of life and vocations, including sophisticated bank robbers who had done time in the highest security prisons, to petty thieves, addicts, prostitutes, blue collar workers, teachers, engineers, ex-housewives and mothers. Although there were differences in the ethnic origins, culture, socioeconomics class, as well as in varying degrees of sanity, there was something we all needed binding us—food and shelter.

Suddenly I became more interested in social issues, not just in the community or nationally, but globally as well. I was not just an American. Now I was part of the family of mankind. I was simply trying to survive like many thousands in all parts of the world.

I amazed myself and spoke to legislators at the capitol and to the Board of Supervisors in Oakland. What a revelation it was to see our voices make a difference.

- Jeannette Hundley
“The trainings have helped me see that mental illness is a disease, just like a physical disease. Most staff needs to be reminded of this.”

Increasing Ability To Care and Advocate For Self and Others

The second focus of the Coaching Elders program helped homeless seniors care for themselves and advocate for change. When clients develop an ability to care for themselves, they often become involved in advocating for change. As they advocate for change, they, in turn, become better able to care for themselves. Senior Advocates for Hope and Justice, and some of the Coaching Elders clients have taken leadership roles. Most of the seniors have never been involved in political action or community efforts before. Now they speak before the Board of Supervisors about cuts in programs, address transit officials about proposed fare hikes for seniors, call into question proposals that would negatively affect seniors, and protest at the State Capitol on Senior Lobby Day.

St. Mary’s Center has designed activities which ultimately help clients become more self-directed, empowered, and advocates for social justice. Some of the activities included:

1. Attending Wellness meetings as part of a regular program for residents of the Winter Shelter. These sessions engage seniors to learn about mental health and addiction, use of medications for treating mental illness, benefits of exercise and meditation, and how to get away from self blame with understanding of the larger social issues that contribute to homelessness. Seniors also receive information about housing, benefits, transportation, places for washing laundry, taking showers, and getting health care.

2. Participating in group activities such as music groups that provide a holistic venue for seniors to stretch their body, mind and heart and interact through conversation, meditation, friendship, and music.

3. Receiving health services from Community Nurses who help monitor medications, provide information about self-care and proper nutrition, and educate about the links between physical health and mental health. Clients reciprocally educate the nurses about health issues specific to homeless seniors.


Home By Dark
by Michael Creedon

I’ve been alone too long
To double-cross myself now.
I went down to the crossroads,
Fixing to die; instead,
I learned to fly.
I’ve been up here too long
To clip my wings now.

When I throw myself up in
The air, I come down standing
On my own two feet.
I’m a toss-up not to
Cross up. Not a pop-up
I still crop up
When they cut down the weeds.

I’ve been around this long
So I might as well stick around.
The buses don’t run very often
Out here, especially on weekends,
But these boots are made for
Walking. I was afraid for so long
I forgot that song. Now I’m
Whistling in the park.
I’ll be home by dark.
“Art Therapy is very powerful. Capitol Hill is divorced from the community; we are drowning in words, rhetoric and testimony. Artwork cuts through abstraction and connects us to the human experience. Send artwork to politicians!”

Bill Goold, Legislative Director to New Jersey Rep. Rush Holt, 2004

“Cry Out For Compassion” by David Wolter

DECREASING STIGMA

The third focus of the Coaching Elders program was to decrease the stigma attached to mental illness among homeless seniors. The targets for this effort were the clients themselves, the staff at St. Mary’s Center, and the larger community.

At the client level, providing mental health and substance abuse counseling in a safe environment was a necessary first step to destigmatizing mental illness. Additionally providing client training, discussing mental health issues in the existing support groups, and having a psychiatrist on site helped the clients become comfortable with the topic of mental illness. Clients are more at ease talking about these issues.

At the staff level, the monthly training on mental illness and substance abuse has enhanced the ability of staff members to be more understanding and accepting of people who are mentally ill and/or addicts.

Changing the attitudes of the larger community has been a more daunting task, but in many ways, a more dramatic one. The outreach activities are too numerous to name here, but two will give a flavor of the work carried out at St. Mary’s Center. One of the most compelling activities was a 12-week art group as part of the Recovery 55 Substance Abuse Program. Using art therapy, seniors expressed their experience of working The Twelve Steps of Recovery. The work of several seniors was showcased in a national exhibit in the Russell Senate Office Building in Washington, D.C. Two of the seniors, neither of whom had ever been to Washington, accompanied a staff member to the opening of the exhibit. They also met with the Legislative Aides to Congresswoman Barbara Lee and Senators Diane Feinstein and Barbara Boxer to talk about the need for affordable housing and health care. The work of Oakland’s artists stood out at the exhibit, as their art incorporated images addressing severe mental illness, substance abuse, poverty, acute health problems, homelessness and violence.
In the second activity, the Center sought to put a human face to the individuals who are so often disregarded. **An Oral History project proved to be an effective way for seniors to share their lives and the tightrope they walk as they deal with homelessness and mental illness.** Through this project, St. Mary's Center has created a powerful medium to give an identity to the real people who struggle daily for survival. Two hundred community members and agencies were invited to a celebration of art, photography and personal story-telling by participating elders, a celebration called "Us Together," named after one artist's painting that embodies the unifying spirit of St. Mary's Center.

**In summary, St. Mary's Center is a trailblazing organization, pioneering programs that address the needs of seniors and urban homeless. Providing leadership training, art therapy, and music lessons to homeless seniors is unheard of.** Recently, two of the agency's programs were recognized at the American Society on Aging Convention in San Francisco, CA for their success and acknowledged for forging new ground by integrating services for dually diagnosed older adults. These accolades would be meaningless, however, if the clients themselves did not benefit from the programs. The next section will examine the impact of this three pronged approach to mental health service delivery for homeless seniors.

"The Dream Is Dead"
*by B’Joli (Beverly Jolivette)*

Crusts of Bread
Crumbs of Crack
The Dream is Dead
The Beast is Back

“Blessed be The Spirit of Art, in a time in the world where the seeds of destruction thrive, and greed rules. I need to create. I see beauty and hope. I am in contact with that spirit. I am a houseless and displaced homemaker. I need to be mother and grandmother but I am not needed. I survive, but I need creative outlets to mold my future. The ugliness of the human condition comes through me, in its rawness, and I attempt to translate it to beauty through art. The world can be a better place. It’s alive in the spirit of art.” ~B’Joli
EVALUATION OF COACHING ELDERS PROGRAM

METHOD

The program evaluator for this project worked collaboratively with the staff and clients, using a Social Action Research approach for evaluating the Coaching Elders program. In contrast to a traditional approach where the evaluator comes into an organization as the expert, with social action research the staff, and at times clients, are actively engaged in planning, implementing, and evaluating the program. Thus the process of evaluation itself becomes a developmental tool for both staff and clients. The research design team for this project determined what data to collect, how to best collect this data, and then how to use this data to improve the quality of services provided through Coaching Elders.

The team determined what units of service should be maintained to assess if indeed the functioning of the Coaching Elders clients improved over time. Additionally it selected the Global Assessment of Functioning assessment tool to track the ongoing mental health of clients. The team also determined to supplement the quantitative data it collected by obtaining qualitative data to further help it evaluate the effectiveness of Coaching Elders.

Three different methods were used to collect qualitative data:

1. Four clients were trained in interviewing skills and then they interviewed a total of thirty Coaching Elders clients. From this data collection process, greater insight was obtained into how the Coaching Elders program has affected the clients' lives.

2. The program evaluator interviewed 15 staff members to identify their perspectives on the Coaching Elders program. The team was especially interested in how staff attitudes and skills have changed, if at all, given the Coaching Elders program.

3. Information was obtained from follow up questionnaires about how the Coaching Elders training has or has not improved staff members’ knowledge and ability to work with clients with mental health and/or substance abuse problems. This questionnaire (as the other documents above) was developed in cooperation with the staff at St. Mary’s Center.

DEMOGRAPHICS

During the life of the Coaching Elders grant, St. Mary's Center provided comprehensive mental health services to approximately 90 clients during the grant period. Currently 60 clients are active in Coaching Elders. Of the 90 clients who were part of the Coaching Elders program, 30 were inactive for reasons such as they moved away, died, were successfully treated, were referred out, terminated treatment themselves, or had increased dementia. The average age for the client group served during this program is 64 while the average length of homelessness was 29 months, with a range of 0 to 16 years. The other demographic variables are summarized in Table One (on page 11).

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2 Of the 90 clients who were part of the Coaching Elders program, 30 were inactive for reasons such as they moved away, died, were successfully treated, were referred out, terminated treatment themselves, or had increased dementia.
SUPPORT SERVICES

Homelessness is a complex issue. There are many factors that result in homelessness including lack of affordable housing for extremely low income seniors, poor money management, poor health, multiple disabilities, mental illness and substance abuse. Research literature suggests that homeless people are more comfortable with receiving concrete services than treatment (Mercier & Racine, 1995). Thus the Coaching Elders case managers often begin addressing basic needs such as housing, clothing, healthcare, and finances before moving onto longer-range clinical services. In fact, the success with providing support services to the Coaching Elders clients often led clients to later seek mental health counseling. Housing is the most important support service required to help stabilize the client. As can be seen below, the vast majority of clients have been stabilized in their living situation.

Ninety-seven percent (58 clients) were homeless upon coming to St. Mary's Center (SMC) and of those who needed housing assistance:

- Ninety-two percent (55 clients) obtained housing.
- Five percent (3) required and received eviction prevention services.
- Three percent (2) needed housing but remained homeless.

Another area that is critically important is stabilizing the finances of the client. The results in the area of financial assistance are also impressive. Thirty-three (33) clients needed financial assistance upon coming to St. Mary's Center. For those needing financial stabilization:

- Ninety-one percent (30) received financial assistance.
- Sixty-four percent (21 clients) received Representative Payee Assistance.
- Thirty six percent (12) got Supplemental Security Income.
- Nine percent (3) obtained employment.
- Six percent (2) received General Assistance.3

Table 1
Summary of Demographics

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<th>Percentage</th>
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<td>Men</td>
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<td>Women</td>
<td>35%</td>
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<tr>
<td>Caucasians</td>
<td>48%</td>
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<td>African-American</td>
<td>37%</td>
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<td>Native American</td>
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<td>Axis I Disorder</td>
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<td>(considered major mental health disorder)</td>
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<tr>
<td>Dually Diagnosed</td>
<td>58%</td>
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<td>(with co-existing mental illness &amp; drug/alcohol abuse)</td>
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3 Some clients received more than one kind of financial assistance.
To summarize, in the areas of housing and financial assistance, approximately 95% of the clients who needed those services received them and obtained positive outcomes, such as housing. With a stabilized living situation and greater financial security, the clients have been in a stronger position to benefit from the mental health services provided by the Coaching Elders program.

**COMPREHENSIVE MENTAL HEALTH SERVICES**

All of the 60 clients served by the Coaching Elders program needed and received mental health counseling. Sixty-three percent or 38 clients received psychiatric evaluations as well and began taking psychotropic medications. Over one third of the clients attended Recovery 55 group meetings, which are based on a modified Harm Reduction and Twelve Step Recovery model.

The GAF (Global Assessment of Functioning) Scale is one of the most frequently used assessment instruments for assessing change in psychiatric patients who have been diagnosed with a mental illness (Tibbo, Joffe, Chue, & Wright, 2002). The GAF Scale considers the psychological, social, and occupational functioning on a continuum of mental health and illness, and thus is an ideal scale to work with the Coaching Elders population. It is based on a scale of 0-100, with scores of 50 or below indicating serious symptoms or serious impairment in social functioning.

At St. Mary’s Center, the GAF Score was assessed upon intake and at three month intervals while the client was actively receiving services. The change in GAF scores over 16-month period of time was quite convincing. A summary of the data is provided in the Table Two below:

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<th>GAF3</th>
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<td>Average</td>
<td>40.8</td>
<td>47.3</td>
<td>53.5</td>
<td>56.02</td>
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<tr>
<td>Median</td>
<td>41</td>
<td>50</td>
<td>55</td>
<td>56</td>
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<td>Percentage of score 50 or below</td>
<td>92%</td>
<td>63%</td>
<td>46%</td>
<td>31%</td>
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<td>(indicating serious symptoms)</td>
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The average percentage of increase in scores from GAF 1 to GAF 4 is a remarkable 37% and the percentage of clients who had GAF of 50 or below decreased by 66%. When tests of significance were run on these data, there were statistically significant differences found between every administration of the GAF test. The data provide convincing evidence that the comprehensive service delivery system provided by St. Mary’s Center does make a major difference in the lives of these clients.

I was homeless for two years. The hotels socked it to me. The rent here was real high and I was out in the cold. The elements started eating me up - the wind, the rain - and I was down on my luck. I was desperate.

Sister Mary took me as her client. It's been going smooth. Sister Mary listens to what I have to say, and I have a lot to say. I see the psychiatrist, once or twice a month. He's got me on some medicines and says I'm doing fine. I've changed a lot because I'm indoors. I'm happy where I'm at.

I don't know where we'd be without places like St. Mary's. The people who work here don't receive big paychecks, yet they seem to enjoy taking care of others. They give of their time, and they're serious. They have compassion for others who need help.

Sister Marilyn, who runs the kitchen, likes to have me around on Sunday. They say I do immaculate volunteer work, and I appreciate that.

The sinful life looks like a lot of fun, but it's not. Sitting in the bars, drinking - it's not a lot of fun. Life today is pretty lonesome, and it's nice to be part of something like St. Mary's.

~ David Fobroy
“I have been surprised at how skilled the clients are in advocating for themselves and to see what survivors they are. With a little bit of care, direction, and concern, the clients are enormously resilient.”

Increasing Client’s Abilities

As has been found in other studies (Cohen, Onserud & Monaco, 1992), the main reason that clients came to St. Mary’s Center initially was for housing assistance (88%) followed by the daily lunch (69%) and money management (56%). After coming to the Center, however, they made new friends, received counseling for mental health issues, significantly reduced their substance abuse or practiced abstinence, and were more socially engaged and willing to speak up for themselves and others. In contrast to most mental health programs, St. Mary’s staff engaged clients in activities that kept them returning to the Center so they would have the support of the community when faced with life’s challenges. Approximately 64% of the clients have been coming to St. Mary’s Center for over a year while 22% have been involved with St. Mary’s for over five years. The vast majority of clients surveyed recognized the importance of having a community, and 84% indicated that they felt a sense of community with their peers at St. Mary’s Center.

The clients who were surveyed see a change in themselves as well as in other clients. When asked about their experience at St. Mary’s Center, eighty-four percent (84%) of the clients suggested that they cope better with their problems since coming to St. Mary’s Center. Seventy-eight percent (78%) indicated that they are now more confident and better able to speak up for themselves.

Destigmatizing Mental Illness

Obviously this is the category that is the most difficult to assess as the stigma of mental illness is widespread and deeply ingrained. At the client level, however, the Coaching Elders program does appear to have made an important impact on how clients view themselves and their future. Seventy-five percent (75%) noted that they are less embarrassed now about the concerns that brought them to St. Mary’s Center in the first place. Additionally forty-four (44%) percent of the clients surveyed indicated that they felt more hope about the future.

I used to be as mean as a snake in mating time. You did something wrong to me, I beat you up bad. Simple as that. Especially when I was drunk.

That’s changed a whole lot since I came to St. Mary’s. They’ve made me look at aspects of myself. Now I’m more calm. If somebody do me wrong, I push it aside.

The staff here, they’re all so friendly, always wanting to help. So I confiscated some of those feelings and kept them for myself. I started doing things for other people, and it made me feel good. You can get enjoyment out of helping someone else when they’re in distress. And the staff likes me for that. They like me quite a bit! They say, “Look at all you’ve done for us.” I feel good just to know that people care that much for me.

This recovery group we have is a combination of drug addicts, alcoholics, and people that’s got pressure on ’em from different things goin’ on in life. There’s a lot of people we have helped. They have come back and said, “I’ve been to a whole lot of recovery groups, and St. Mary’s is the best one there is.”

~ James Jermay
III - Lessons Learned

The mental health component was a new addition to the agency, so a great deal of effort was placed on education, skill, and program development. The overriding principle, however, was to make effective changes without compromising the spirit and mission of St. Mary’s Center. To that end, the Center hired mental health professionals who they knew would integrate the mission with the methodology.

Program Implementation

1. Focusing on the mission itself helped to dissipate political and professional differences between multi-disciplinary staff during efforts to create a holistic treatment model. Together, staff and clients created a pioneering model to best serve homeless and multiply diagnosed seniors. The Center engaged staff and clients in invigorating brainstorming sessions. Both resistance and transformation occurred throughout the evolution. In the end, the organization discovered that what they were actually doing, in practice, fit a Dual Diagnosis and Modified Harm Reduction Model.

The Center originally had a hands-on social work model. Over time, the Center developed an abstinence based substance abuse program for seniors. Both social workers and substance abuse counselors recognized the need for mental health services and were very eager to develop a mental health component. However, both were leery of the influence of a mental health model. Substance abuse counselors and clients feared addicts would be “psychopathologized,” and that the unique knowledge base of addiction specialists would be under valued. Some were skeptical about the effectiveness of a Harm Reduction versus Abstinence Model of recovery. Social workers feared that mental health professionals would maintain rigid boundaries with staff and clients and not participate in the hands-on work of helping to comprehensively case manage the clients. Incoming mental health professionals were challenged to modify traditional therapy format and interventions to fit the needs of a transient, older adult population unaccustomed to, or leery of mental health treatment.

Dual Diagnosis trainings were held for all staff. Harm Reduction concepts were debated. Tolerance for people’s ambivalence and expression of concerns was essential. Everyone’s ideas were valued and discussed, and sifted in or out by collaborative consensus.

Reduction of harm, across the board, became the focus of treatment, starting wherever the client was willing. Hope of abstinence, versus a strict abstinence model of treatment, was agreed upon. Rules governing the Center were modified to reflect behavioral concerns and safety versus drug/alcohol use. Respect for elders and staff was the guiding principle overlaying all discussions about methodology. Staff and clients rallied as demonstrated effectiveness emerged from changes.
“I don’t feel as alone. 
With the staff’s guidance, genuine care, and great spirit, I found inner strength, motivation, and hope that I did not know existed in me. I feel like I’m just starting to live. Hopefully the best is still to come.”

2. **St. Mary’s undertook an unusual approach by providing training in mental illness and substance abuse to all staff members regardless of their position.** Staff members in the kitchen, dining room, drop-in center, shelter, administrative offices and those providing direct services, are now more sensitive to and respectful of the client. This contributes to an increasingly therapeutic environment for the clients. Additionally, the support staff seek out advice and counsel from the social workers when confronted with challenging clients rather than dismissing them from the drop-in center, for example, as they may have done in the past.

3. **Professionally trained staff with case managers skilled in assessment, counseling, and evaluation is an essential component of the Coaching Elders program.** In order to transition from a social service program to one that provides mental health and dual diagnosis services as well, the skill level of the social service staff must increase dramatically. One case manager described this shift in this way: “In the past most workers had a general understanding of mental illness but most of our work focused on helping clients get housing and our services rarely went beyond that. Now [case managers] are more competent, better trained, better able to identify and diagnose, and then develop treatment plans with that diagnosis in mind.”

4. **An important part of St. Mary’s success can be attributed to its approach of offering integrated treatment for clients with co-occurring mental illness and substance abuse disorders.** Research has shown that an integrated approach for treating this client population is a superior approach, resulting in reduced alcohol and drug use, homelessness, and severity of mental health symptoms (Wells et al., 2003). Though more effective, such programs are extremely rare and even more so when working with homeless elders.
5. **St. Mary's has continued to provide a wide array of support services for clients to complement the mental health services.** As one employee noted, it is important for the Center to "provide food, a drop in center, and music groups as warm ups to get the client interested in receiving services. The Center needs to have a 'hook' and respond to their interests and needs to address more holistic needs. In other words, something the clients want in order to ultimately get them to receive services." Interestingly, research indicates that clients remain in treatment programs at a higher rate when the treatment is combined with other services such as housing, income support and the like (Wells et al., 2003). This has been St. Mary's experience as well.

6. **When asked what advice they would give others interested in starting a program comparable to Coaching Elders, many staff members said "Provide easy access to psychiatric evaluations and medications through the services of an on site psychiatrist."** They discussed the importance of having a psychiatrist at the agency to help with client evaluation necessary for obtaining SSI, other entitlements and medications. One staff member introduced an interesting benefit by stating that "the psychiatrist helped normalize mental illness for the clients and by his presence, added validity to the client problems." Other staff members were pleasantly surprised by how readily the clients had taken to seeing the psychiatrist and to how many are now regularly taking their medications.

7. **Attention was paid early on in the Coaching Elders program to determine what outcome data would be collected - data on how many clients were served, and data to help staff members know if they were achieving meaningful results.** Articulating outcomes and collecting data to assess outcomes has not been a strong focus in human service agencies, but increasingly successful organizations are recognizing that outcomes matter. Such information has served as a springboard for staff discussions on how to continually improve their effectiveness.

8. **As an intentional part of its therapeutic approach, St. Mary's Center has built a viable community of treated clients who stay involved with the center, helping to maintain their own recovery as well as that of other clients.** As mentioned previously, 84% of clients surveyed indicated that they felt a sense of community with their peers at St. Mary's Center. The Center has helped to fill a void in the lives of many homeless seniors, and through their participation at the Center, seniors now have a sense of community and connectedness that has long been missing in their lives. This is a remarkable accomplishment given the significant challenges facing the clients served by this organization.
“People love working here. 
There is a profound level of working in harmony with a shared vision and mission. 
People have a calling to the work, and all are strengthened by this.”

St. Mary’s Center Staff Member

2. The agency has courageous leaders at every level of the organization including the clients themselves. Rather than acting from self-interest, they act out of service, and instead of attempting to control, they create partnerships and also hold themselves accountable to those over whom they hold power. They lead by example and are willing to take action on behalf of their beliefs.

The Executive Director forcefully speaks out about the injustices she perceives in today’s society. The staff members in the agency organize trips for clients to visit legislators and to rally on behalf of a cause, and they too participate with the clients. Some have risked being arrested for demonstrating, though they are not rabble rousers or malcontents. The leaders at St. Mary’s Center have deeply held beliefs, which they will not compromise, and this is evident to the staff, clients, and community members. The leaders’ courage helps the clients be more courageous and that contributes to the clients feeling more self-confident and hopeful for their future.

Organizational Culture

There are many intangible factors related to the culture and spirit of the Center that provide additional clues to St. Mary’s Center’s accomplishments:

1. St. Mary’s Center functions as a mission-based organization. While having a mission is standard practice in most human service organizations, having a mission-based organization is much less common, probably even a rarity. With these rare organizations, the mission becomes the basis upon which decisions are made and priorities established; personal and political agendas become secondary. In such organizations, top managers, board members, and staff “exist to serve the mission rather than the mission serving them” (Proehl, 2001, p. 13).
3. **St. Mary’s Center is one of the rare organizations where power is decentralized and employees are empowered to make decisions in areas where they care deeply.** The great irony in many human service organizations is that the stated purpose is to help clients become more self-directed, self-sufficient, and autonomous so they will no longer be dependent on assistance. And yet the very staffs that are assisting them are working in organizations where decision making is centralized, information guarded, and autonomy stifled by extensive guidelines and regulations (Proehl, 2001). At St. Mary’s Center, the staff members become partners with the leaders as they engage in the important work of helping the clients become self-directed.

When staff members are empowered, they are more likely to involve the clients in the operation of the agency as well, and as a result, the clients continue to improve in their functioning. They become partners with the staff, just as the staff members are partners with the leaders. This is done through such innovative initiatives as the art projects, oral histories, music group, interviewing teams, public speakers, and the like. The clients also become visible and validated stars through newspaper articles written about them, exhibits of their artwork, their life stories placed on the internet, and their music appreciated by the community.

4. **Faced with shrinking budgets and increasing social problems, successful programs collaborate with other organizations, volunteer groups, and educational institutions to provide creative services.** St. Mary’s Center has done this by recruiting and retaining a large cadre of volunteers and students who work with them in a wide range of capacities from clerical workers to highly skilled professionals. This unpaid workforce helps the agency extend its services.

The key to St. Mary’s Center’s success in retaining volunteers is its willingness to be partners with the volunteers. In partnership, there is mutual responsibility for achieving a shared goal, and the partners are "connected to another in a way that the power between [them] is roughly balanced" (Block, 1993, p. 28). At St. Mary’s Center, volunteers and students feel the same commitment to the mission as the staff, and with a committed volunteer pool, the arms of the agency are expanded to places that staff alone could not reach.

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I was in Berkeley, camping out at their famous People’s Park. I went to Traveler’s Aid and asked a woman there, “Look, it’s cold out there, and I’m pretty much crippled up. Do you have any place where a man my age can go?”

I was processed into the shelter at St. Mary’s. I was tired and dirty, must have looked like hell. And I was highly confused. But I knew if I stayed put, I could break this homeless chain. The chain’s been broken. It took some help, and a lot of effort on my part.

I suffer Post Traumatic Stress Disorder. I carry memories from Vietnam. With the Psychiatrist at St. Mary’s, I have one-on-one counseling sessions. I have to learn new skills, new ways of living. I’ve got to disassemble the old timbers and start all over again.

Stop The War is born out of my being in Vietnam. I have a constant memory and fear of war. I’ve learned how to stuff it. I had to, if not, I’d go out of control and couldn’t do anything to help myself or anyone else. When I drew this image I allowed myself to feel the cannon fire, the bombs dropping, and to hear the people yell out. It was a walk through fire and I felt cleansed.

I’ve become devoted to a cause, housing and social services for poor people. I go to public meetings in Sacramento and Oakland, and I speak out. I’m a brand-new activist. Brand, spanking new! It’s not just for myself, it’s for others.

~ Ken Minor
Dream
by Johnny Culver

Some people Lose the pleasures of Today
Because of the pains of yesterday.

Some people Lose their Dreams
Because for them, Losing is the Only way

Some people Drown in Self Pity;
they Only Grow Old and Gray

Some people Give Up on Life;
They Live in Silence, Until Dead they Lay

Some people Keep up the Dream; For Them,
Yesterday is Gone and
Tomorrow Never Comes;

They Live For Today.

The Dream Lives; Even Today

"The Star" by Tyrone Davis, a Coaching Elders participant in dual diagnosis recovery.

"Peace" by Celestine Ward,
a Coaching Elders participant and Hope and Justice advocate.

we are she/ she is me
I am woman alone/ and strong
through the eons/ of all the tribes
without applause/ alone, and strong
our men/ work-worn for the wealthy
our sons/ cannon-fodder for the greedy
knowing, but sowing, nurturing
with tears and love the seeds
of hope for the future
alone and strong

~ B’ Joli (Beverly Jolivette)
As an organizational psychologist and former social worker, I have spent many hours wondering why St. Mary's Center is so special. With that said, I am not blind to the problems that exist at the agency, to the conflicts that occur, or to the staff and clients who are disgruntled at times. But in the big picture, St. Mary's Center is a charmed agency, devoid of the struggles that plague so many of our human service organizations. I have tried to capture the programmatic variables that have contributed to St. Mary's Center's success. They include such factors as providing a safe and supportive environment for the clients, having intensive case management, and offering integrated treatment for co-occurring mental illness and substance abuse disorders. Additionally St. Mary’s Center has professionally trained staff, a wide array of support services for clients, and easy access to psychiatric evaluations and medications through the services of the on site psychiatrist. As suggested previously, all of these factors are crucial to effectively serving the elderly homeless with mental health problems.

It is my belief, however that the deeply engrained values of social justice, respect for the dignity of the individual and willingness to share power are the real keys to St. Mary’s Center’s achievements. When the staff members and volunteers live out of these values, the results are nothing less than miraculous. A drug addict and self-described loner who was found living in his truck describes his personal transformation in this way:

“St. Mary's has brought things out of me that I didn't know about. Some people say that I have opened up more since I have been here. I like that! I just started gradually, like a flower, budding out. I started blooming.”

St. Mary’s Center Client

This is but one of the individuals whose lives have been changed by the spirit of St. Mary’s Center.

Rebecca Proehl
Berkeley, CA
APPENDIX A

REVIEW OF THE LITERATURE

In recent years, the number of homeless individuals who are over 50 has grown, and the numbers are expected to increase as the homeless problem and elderly population continue to escalate. In the past thirty years, the age group over 65 grew by 74% and in the next thirty years this group will account for 20% of the total population, which is up from 13% in 2000 (http://www.aagpga.org/prof/facts_fh.asp). At the same time the aging population is growing, the amount of affordable housing is decreasing, thus making the marginally housed even more vulnerable (Rosenheck, Bassuk, & Saloman, 1998). The estimates of the aging homeless vary considerably, ranging from 6 to 27% of the total homeless population (Kutza & Keigher, 1991), but the numbers alone do not tell the whole story of this vulnerable population.

The elderly homeless need special attention as their age makes them especially defenseless; their options for reintegration into society are few; and their physical abilities to withstand hardships of being homeless or living in shelters are limited. Additionally they often lack a network of relatives and friends, and their impaired judgment may lead to financial mismanagement and exploitation. Complications of aging can also affect the treatment process: the decline in hearing and seeing may create a lack of trust and hyper-vigilance among the clients; they may prefer to remain on the streets because they are often targets in shelters; and the elderly homeless often fear that their independence will be limited or worse, they will be institutionalized (Cohen & Sullivan, 1990; Keigher, Ahrens, & Lumpkin, 1987; Kutza & Keigher, 1991; Rosenheck et al., 1998).

Further there is general agreement that approximately one-third of the single adult homeless population suffers from a severe mental illness; the percentage of mental illness among the homeless is significantly higher than that of the domiciled population (Wells, Williams, & Dennis, 2003). The symptoms of mental illness may render individuals more vulnerable to homelessness or marginal housing, and given this susceptibility, it has been estimated that as many as two-thirds of the seriously mentally ill have been homeless or at risk of becoming homeless (Tessler and Dennis in Wells et al., 2003). To understand the struggles that this population faces and the challenges posed when serving them, we must first understand the hazards faced by the homeless, the elderly, and the mentally ill.

HOMELESSNESS, MENTAL ILLNESS, AND SUBSTANCE ABUSE

The mentally ill homeless are often considered to be “treatment resistant”. The reasons for their noncompliance are many. For example, they may have had negative experiences with mental health services in the past; may give higher priority to procuring their basic needs such as food and shelter; and may not recognize their mental illness (Cohen, Onserud, and Monaco, 1992). Additionally as suggested above, there is often resistance from traditional service providers to work with this population, thus making it difficult for the homeless to receive mental health treatment services (Ladner in Rosenheck et al., 1998).

In addition to mental illness, the homeless population also struggles with substance abuse problems. Approximately one-half of all individuals who are homeless have substance use disorders at some time in their life (McMurray-Avila in Wells et al., 2003), and approximately 50% of the homeless with serious mental illness have a co-occurring substance use disorder (Fischer and Breakey, 1991). The combination of mental illness and substance abuse make it even more difficult for the homeless individual to find suitable housing "because they tend to have more severe mental symptoms, to deny both their mental illness and their substance use problems, to refuse treatment and medication, and to use multiple substances" (Wells et al., 2003, p. 3).

THE ELDERLY AND MENTAL ILLNESS

Current research on the homeless elderly with mental illness is quite limited. We do know, however, that for the general elderly population, mental illness will increase from 4 million in 1970 to 15 million in 2030, or by 166%. There is evidence that this group has a higher incidence of mental illness than previous generations including a higher rate of substance abuse. Further given their increased longevity, the numbers of individuals who become mentally ill late in life has escalated, linked to chronic physical conditions or neurological disorders such as Alzheimer’s (http://www.aagpga.org/prof/facts_fh.asp). Additionally we know that the rate of mental disorders are underreported for the elderly population and that one-half of older adults with mental health problems receive treatment from their health care provider.
Only 3% receive help from mental health specialists, stemming from reasons of stigma, self-denial of mental health problems, lack of collaboration and coordination between mental health and aging networks, and shortages of appropriate health professionals (http://www.psych.org/publiconor/elderly.cfm).

While the current research on the homeless elderly with mental illness is sparse, there have been a few well-developed studies completed within the last ten to fifteen years. In two studies of the elderly "new homeless", the researchers found that only a small percentage of the elderly population at risk fit the stereotype of skid row homeless clients, suffering from psychological or alcohol problems and frequently using shelters. The majority were marginally housed or recently homeless, in poor health, extremely impoverished, and quite vulnerable. They often were in need of protective services and frequently unwilling to ask for help. In one of the studies, 27% of older homeless individuals showed psychological or alcohol-related symptoms. In another study, 45% of the women and 31% of the men were confused, disoriented or paranoid (Kutza& Keigher, 1991).

Cohen et al. (1992) conducted a longitudinal study to examine the impact of an age-segregated, low-demand, multi-service community agency on the lives of the homeless and marginally housed elderly. Not surprisingly, only a handful of clients initially requested services to help with alcohol problems though one-fourth of clients had this problem, and no clients requested mental health services though two-thirds of them had current or previous psychiatric problems. The most frequently mentioned presenting problems were requests for food (68%) and assistance with obtaining entitlements (28%). Speaking to the effectiveness of the age-segregated, community agency approach, the researchers found that the vast majority of clients (93%) had two or more favorable outcomes, and those who had one successful outcome were likely to have several.

**Treatment of the Mentally Ill Homeless**

As is evident from the discussion thus far, the elderly homeless population with mental illness and/or substance abuse problems is certainly one of the most susceptible populations served by human service organizations. The challenges of working with these clients are extreme and successful models are rare though there are lessons to be learned from the literature, which has examined programs for the mentally ill homeless.

For example, the Federal Task Force on Homelessness and Severe Mental Illness (1992) offers hope for treating this vulnerable population. They concluded that “homeless persons with severe mental illness will partake in services, if the service system can break out of the mold of traditional service provision and becomes responsive to their needs” (p. 360). The Taskforce recommended "safe-haven" programs, namely, small and supportive environments with linkages to more specialized services to serve the hardest-to-reach portion of the homeless mentally ill population.

Similarly in a study on the effectiveness of programs serving homeless adults with serious mental illness in California, dramatic results were achieved when intensive outreach and community based services were employed. Psychiatric hospitalization dropped by 66%, days of incarceration by 82%, and the number of days spent homeless dropped 79% (California Department of Mental Health, 2002).

This message is echoed in the recently published document, entitled Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and Co-occurring Substance Use Disorders. They optimistically began their report with the following conclusion: "The good news about service provision with serious mental illness and/or co-occurring substance use disorders who are homeless can be summed up simply: We know what works. Now we need to put what we know to work " (p. 1). They emphasized the importance of having aggressive outreach programs, providing intensive case management, and offering integrated treatment for co-occurring mental illness and substance abuse disorders. They further accentuated the importance of having self-help programs and involving individuals who were formerly homeless in treating this population (Wells et al., 2003). They concluded that the success of such programs occurred when they focused on choice, dignity, and respect, ingredients often missing in our service delivery systems (Glasser in Wells et al., 2003).

In conclusion, while it is evident that the elderly homeless with mental illness and/or substance abuse problems are an extremely vulnerable population, there is hope in the literature that they can be effectively served by age-segregated, multi-service community agencies.
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