

PRACTICE FORUM

# Social Justice, Respect, and Meaning-Making: Keys to Working with the Homeless Elderly Population

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*I don't look you in the eye, I'm ashamed, but I see you.  
Do you know that I am more than I appear?  
For God's sake, see the real me.*  
Fuhr, 1996, p. 2

In U.S. culture, people do not like to believe that their grandparents, great uncles and aunts, and aging parents might suffer from severe mental illness, much less that they may be substance abusers or alcoholics. Consequently, we often deny that elderly people with mental illness and addictions exist, or if they do, we consider them to be anomalies. Substance abuse programs designed for the special needs of older adults are rare in the United States, and traditional mental health providers are often reluctant to work with the population, thus making it difficult for the homeless older adults to receive mental health services (Ladner, cited in Rosenheck, Bassuk, & Saloman, 1998). As a society, we have been slow to accept the growing need for age-specific treatment services for elderly people, especially homeless elderly individuals. It is easy to distance ourselves from the problem of homelessness, telling ourselves "it could never happen to any seniors I know," but in fact, "it" is increasingly happening to elderly people.

## LITERATURE REVIEW

In recent years, the number of homeless individuals who are older than 50 has grown, and the numbers are expected to increase as the homeless problem and elderly population escalates. At the same time that the aging population is growing, the amount of affordable housing is decreasing, thus making the marginally housed individuals even more vulnerable (Rosenheck et al., 1998). Estimates of the aging homeless population vary considerably, ranging from 6 percent to 27 percent of the total homeless popula-

tion (Kutza & Keigher, 1991), but the numbers alone do not tell the story of this population.

Elderly homeless people need special attention as their age makes them especially defenseless; their options for reintegrating into society are few; and their physical ability to withstand the hardships of being homeless or living in shelters is limited. 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 vision may create a lack of trust and hypervigilance among elderly homeless people; they may reluctantly choose to remain on the streets because they are often targets in shelters; and they often fear that their independence will be limited, or worse, that they will be institutionalized (Cohen & Sullivan, 1990; Keigher, Ahrens, & Lumpkin, 1987; Kutza & Keigher, 1991; Rosenheck et al., 1998).

There is general agreement that approximately one-third of the single adult homeless population suffers from a severe mental illness, and the percentage of mental illness among homeless people is significantly higher than that of the domiciled population (Wells, Williams, & Dennis, 2003). In addition, approximately 50 percent of homeless people with a serious mental illness have a co-occurring substance abuse disorder (Fischer & Breakey, 1991). The symptoms of mental illness or substance abuse disorders 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 people with a serious mental illness have been homeless or at risk of becoming homeless (Tessler & Dennis, cited in Wells et al., 2003).

With regard to treating this population, the Federal Task Force on Homelessness and Severe Mental

Illness (1992) noted that "homeless persons with severe mental illness will partake of services, if the service system can break out of the mold of traditional service provision and becomes responsive to their needs" (p. 360). The task force 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.

This message is echoed in a more recently published document *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and Co-occurring Substance Use Disorders* (Wells et al., 2003). The authors 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 value of having self-help programs and involving individuals who were formerly homeless in treating this population. The report concluded that these self-help programs are successful because they focus on choice, dignity, and respect—ingredients that unfortunately are often missing in our service delivery systems (Glasser, cited in Wells et al., 2003).

#### PROGRAM DESCRIPTION

Saint Mary's Center, founded in 1973 by a Catholic parish, is now an independent nonprofit organization serving the poor and homeless elderly population in a large city in California. It provides comprehensive services for people age 55 and older from all racial, cultural, and religious backgrounds. For years the agency offered outreach, housing stabilization, medical care, financial management, meals, nursing, substance abuse counseling, a winter shelter, and support groups for the elderly population. The case managers over time, however, estimated that approximately 70 percent of their homeless clients struggled with mental illness, substance abuse, or both. Not feeling adequately trained to treat this population, the staff at Saint Mary's Center sought and obtained funding for three years to provide services for the elderly homeless people with mental illnesses.

Saint Mary's Center is housed in the heart of the community it serves; benches and trees in front of the center provide a welcoming place for clients. Much of the interaction between staff and clients takes place in the informal outdoor environment, helping to forge trusting relationships between the two. The facility is open, accessible, and welcom-

ing with artwork created by the clients displayed throughout. A dining room serves as a place for meals, a drop-in center, a nursing station, and an emergency shelter in the winter. More than 100 homeless older adults, on average, are sheltered annually from December through April, and altogether 400 homeless older adults receive services at the center each year. Although clients are often referred by other agencies, many come after hearing positive reports from their peers.

Although the agency provides direct services for poor and homeless older adults, its goals are broader and more ambitious than service delivery only. The underlying agency philosophy is to address the deeper social and economic problems that contribute to poverty, mental illness, and homelessness. In addition to the strong social justice orientation, there is a spiritual environment present in the organization, although 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).

Given the unique culture of Saint Mary's Center and the needs of this population, it was apparent to agency leaders that **comprehensive services and extended engagement with the clients** must become the basis for the ongoing treatment process. What organically emerged was an age-specific, holistic program in which multiple, integrated services are provided at one location. The staff members work with the clients to reduce risk in their lives, to sustain their independence, and to help build a community where the older adults feel welcomed and valued. And perhaps most important, the client guides the pace and priorities of his or her individualized treatment plan.

With this approach, a wide array of services is available for clients who can access them in the order in which they choose and in the time that is appropriate for them. For example, one client named Joe came to Saint Mary's Center because he wanted food and shelter; he did not want help with his addictions, and he did not know he had a mental illness. Today, Joe participates in this holistic program; he has been housed for four years and is usually stable, with episodic setbacks. Three years ago, he started taking medicine prescribed by a psychiatrist to stabilize his moods. Consequently, he has been able to steer clear of heroin and alcohol for 2 ½ years by attending recovery meetings designed

for older adults with co-occurring mental illness and addictions. He is a strong advocate for social justice and is pursuing an associate of arts degree in social services. He routinely uses art to explore therapeutic themes. Occasionally Joe's mental illness gets the best of him, and he mismanages his medications and drinks alcohol again. Most important, however, he quickly seeks assistance and recuperates.

Other clients like Joe also enter the treatment process through a variety of "doors" rather than entering through a designated first step and progressing neatly through a treatment program. At times, clients will relapse and may need to obtain support and services anew as challenges arise. They may also move in and out of their relationship with Saint Mary's Center, given their life circumstances. Some clients will never achieve the kind of stabilization that lends itself to mental health and sobriety; although, they too are welcomed and respected in the Saint Mary's community.

In all, however, the major services available to the homeless elderly clients fall into three main categories. Although the first two are important to the client's overall health and safety, the last distinguishes Saint Mary's approach from most other programs:

- psychosocial adjustment: stabilizing the client's housing, finances, mental health, and sobriety
- self-direction: helping clients to assume self-direction and control in their lives
- meaning-making: providing opportunities for clients to achieve meaning and affirmation in their lives.

Given the culture of the agency, these services are provided in a context of unconditional emotional support where clients are led to "believe that [they are] cared for, loved, esteemed...with a network of mutual obligations" (Barrett & Soltys, 2002, p. 57).

## OVERVIEW OF THE TREATMENT PROCESS

### Psychosocial Adjustment

With new funding, Saint Mary's Center was able to hire new professionals, including a part-time psychiatrist. The newly hired, licensed social workers took steps to increase the professional competence of existing staff members to supplement their commitment to serving the poor population. The initial steps taken included providing extensive training for case

managers and outreach workers on mental health and substance abuse issues of the elderly population. Emphasis was placed on building assessment skills, developing new intake tools, preparing comprehensive care plans, monitoring the progress of the program's clients by conducting case reviews, and using standardized assessments and other measures to determine client progress. One unique feature of this program was holding monthly training sessions with all staff members in the agency on issues related to mental illness and substance abuse. This ambitious undertaking was necessary so that all staff members, including those working in the kitchen, shelter, drop-in center, and office would have a solid understanding of mental illness and sensitivity to the plight of the mentally ill client.

The literature suggests that homeless individuals are more comfortable receiving concrete services rather than treatment (Mercier & Racine, 1995). Thus the case managers often addressed the basic services such as housing, clothing, health care, and the like before initiating longer-range clinical services. With a part-time psychiatrist on-site, clients had greater access to psychiatric evaluations, which were necessary for obtaining Supplemental Security Income, other entitlements, and medications—often necessary precursors to stabilizing the client's housing and finances. Once clients were stabilized in their housing, finances, medications, and so forth, they were more inclined to later seek mental health counseling. Counseling was provided individually with either the on-site psychiatrist or the trained case manager and in group counseling with trained case managers.

### Self-Direction

The second aspect of the treatment model was to help homeless older adults assume charge of their own lives. Thus agency staff designed activities that ultimately helped clients become more self-directed and empowered. Some of the activities included clients attending wellness meetings, where they learned about the symptoms of dual diagnosis, the use of medications for treating mental illness, and the benefits of exercise and meditation. They also participated in the Wisdom Center and Music Groups that provided a venue for them to stretch their bodies, minds, and hearts in settings that invite conversation, meditation, and music. They received health services from community nurses who monitored medications, provided information about self-care

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and proper nutrition, and educated about the links between physical and mental health. In addition, they regularly participated in Chinese New Years, Black History Month, and Philippine Independence Day celebrations to learn more about each other's cultural heritage.

### **Meaning-Making**

The third aspect of the treatment approach encompasses a wide range of activities to help clients achieve meaning in their lives. It is well documented that humans have a need for meaning (Frankl, 1959) and that a "focus on meaning and purpose provides a positive, optimistic perspective that is counter to disempowering views of aging based on losses and deficits" (Penick & Fallshore, 2005, p. 17). Developmental psychologists have long recognized that personal meaning is a key component of successful aging (Erikson, 1963), and even more so in old age, when one's sources of meaning are at greatest risk, given the losses of personal relationships, career, and community roles.

The major sources of personal meaning, including personal relationships, personal growth, success, altruism, hedonism, creativity, religion, and legacy, do not change substantially over the life span (Penick & Fallshore, 2005). With the homeless elderly population, however, most clients do not have access to the very sources necessary to achieve this meaning in their lives. They frequently have lost their careers, relationships with family and friends, material possessions, association with formal religion, and interest in personal growth and creativity. So an important aspect in helping older adults **sustain** their mental health and sobriety is centered on meaning-making.

Unlike other treatment programs, Saint Mary's Center does not terminate clients once they have been stabilized. Rather, an intentional part of the approach is to build a viable community of treated clients who stay involved and connected to the center. At the center, the older adults are artists and historians; they are fundraisers and advocates; they are musicians and peer counselors. Through these vari-

ous media, they are helping to change how society views the homeless elderly population with mental illnesses and substance abuse, and they are becoming healthier as the outreach activities in which they are involved provide meaning in their lives.

The meaning-making activities are too numerous to name here, but three will give a flavor of the work carried out at Saint Mary's Center. One of the most compelling activities was a 12-week art therapy program in which older adults focused on the Twelve Steps to Recovery. At the end of the process, their creative work was showcased, including a national exhibit in the Russell Senate office building in Washington, DC. In the second activity, an Oral History project proved to be an effective way for older adults to share their legacy by putting a face on the individuals who are so often disregarded. Through this project, Saint Mary's Center has created a powerful medium to give an identity to the individuals who struggle daily with homelessness and mental illness. With the third activity, a group known as Senior Advocates for Hope and Justice has become involved in political action and community organizing. Although never involved before, the homeless and the formerly homeless populations are now speaking before the Board of Supervisors about cuts in programs, addressing transit officials about proposed fare hikes for older adults, calling into question proposals that would negatively affect older adults, and protesting before the state capitol on Senior Lobby Day.

### **EVIDENCE-BASED SUCCESSES**

In 2004–2005, Saint Mary's Center conducted a one-year evaluation of 90 clients to test the efficacy of their therapeutic model. Attention was paid early on to determine what outcome data would be collected to help staff members know whether and when they were achieving meaningful results. At the time of the evaluation, 60 clients were active in the program. (Of the 90 clients who were part of the Coaching Elders program, 30 were inactive because 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 was 64. Sixty-five percent of the clients were men, and 35 percent were women. White clients represented 48 percent of the population; African Americans, 37 percent; Latino clients, 12 percent; and Native Americans, 3 percent. The average length of homelessness for this

group was 29 months, although the range extended from zero to 16 years. All of the clients in the program had an Axis 1 diagnosis, which is considered a major mental health disorder. Fifty-eight percent of the clients were dually diagnosed with a coexisting mental illness and drug or alcohol abuse.

Ninety-seven percent ( $n = 58$ ) were homeless upon coming to Saint Mary's Center, and of those who needed housing assistance, 95 percent ( $n = 55$ ) obtained housing. Thirty-three clients needed assistance in securing a steady source of income or in having their money managed upon coming to Saint Mary's. For those needing those services, 91 percent ( $n = 30$ ) received a positive outcome in this area. With a stabilized living situation and greater security in the financial area, the clients have been in a stronger position to benefit from the mental health services provided by the program.

All 60 clients served by the program needed and received mental health counseling. Ninety-two percent ( $n = 55$ ) of the clients had improved Global Assessment of Functioning (GAF) scores over time. GAF is one of the most frequently used instruments for assessing change in psychiatric patients who have been diagnosed with a mental illness (Tibbo, Joffe, Chue, Metelitsa, & Wright, 2001). 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 use with this population. It is based on a scale of 0 to 100, with scores of 50 or below indicating serious symptoms or serious impairment in social functioning.

During the past year, case managers used GAF to assess each active client every four months. The average percentage of increase in scores from GAF 1 to GAF 3 was 31 percent, and the percentage of clients who had GAF scores of 50 or below decreased by 66 percent. When tests of significance were run on these data, statistically significant differences were found between the GAF 1 and 2 scores, GAF 2 and 3 scores, and, of course, between GAF 1 and 3 scores at .001 level of significance.

The clients saw a change in themselves and in other clients. For example, when surveyed about their experience at Saint Mary's Center, 84 percent ( $n = 50$ ) of the clients suggested that they cope better with their problems since coming to Saint Mary's Center. Seventy-eight percent ( $n = 47$ ) indicated that they were more confident and better able to speak up for themselves. Seventy-five percent ( $n = 45$ ) noted that they were less embarrassed now about

the concerns that brought them to Saint Mary's Center in the first place. And finally, 44 percent ( $n = 26$ ) indicated that they felt more hope about the future. One client said it this way: "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 don't feel as alone. I feel like I'm just starting to live. Hopefully the best is still to come." More than one-half of the active clients were surveyed for the program evaluation. Four of the clients were trained in interviewing skills and conducted the interviews with their peers.

### LESSONS LEARNED

Many factors enabled the agency to achieve such impressive results with this challenging population. The first set of variables is related to the quality of the staff and the types of services provided:

- Having professionally trained staff skilled in assessment, counseling, and evaluation was an essential component of the program. To transition from a social services program to one that provides mental health and substance abuse services, the skill level of the social services staff had to increase dramatically. This increase in skill level occurred through ongoing training, supervision, and case conferences.
- The agency continued to provide a wide array of support services for clients to complement the treatment component. Interestingly, research has suggested 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 was Saint Mary's experience as well.
- With this population, it was critical to have easy access to psychiatric evaluations and medications through the services of an on-site psychiatrist. Interestingly, the psychiatrist helped normalize mental illness for the clients and added validity to their problems. The agency staff members were pleasantly surprised to see how readily the clients took to seeing the psychiatrist and to how many freely took their medications. The agency managed the finances for many of the clients, which reduced the risk that clients would misuse their finances and ultimately end up homeless again.

- Attention was paid early on in the program to determine what outcome data would be collected to help staff members know if and when they were achieving meaningful results. Articulating outcomes and collecting data to assess outcomes has not been a strong focus in human services agencies, but increasingly successful organizations are recognizing that outcomes matter (Altshuler, n.d.). Such information has served as a springboard for staff discussion on how to continually improve their effectiveness.

Other important factors, which stemmed largely from the culture and values of the organization, affected how the services were provided and by whom. They included the following:

- There is an internal congruency at Saint Mary's Center that is noticeable to all who enter the environment. The commitment to social justice and respect for the client is palpable. The leaders have deeply held beliefs that they will not compromise, which is evident to the staff, clients, and community members. It is reinforced by the types of activities that the agency sponsors, the executive director's speeches, the way clients are treated, the pictures on the walls, and more. Clients remark that they feel safe at Saint Mary's and that they feel valued for who they are.
- Agency leaders used creative strategies to help dissipate professional differences between staff members as they created a holistic treatment model. They engaged staff from different disciplinary backgrounds in brainstorming sessions to develop the new model. The guiding principle for decision making about the new program was always the mission; personal and political agendas became secondary, and staff members worked "to serve the mission rather than the mission serving them" (Proehl, 2001, p. 13). The end result has been an unswerving dedication to **servicing** clients.
- Agency leaders undertook an unusual approach by providing training in mental health and substance abuse to all staff members, regardless of their position. This contributed to an increasingly therapeutic environment for the clients. For example, when confronted with challenging clients, ultimately support

staff began to seek out counsel from the social workers rather than dismissing such clients from the drop-in center, as they may have done in the past.

- Unlike many other programs, Saint Mary's created a welcoming environment for clients, where they were encouraged to participate actively in the community. The center has helped fill a void in the lives of many homeless older adults, and through their participation, older adults now have a sense of community, connectedness, and meaning that has long been missing in their lives.
- Faced with shrinking budgets and increasing social problems, successful programs collaborate with other organizations, volunteer groups, and educational institutions to provide creative services (Altshuler, n.d.). Saint Mary's Center has a large cadre of volunteers and students who work with them in a wide range of capacities, from clerical workers to highly skilled professionals. Interestingly, volunteers and students feel the same commitment to the mission as the staff, and with a committed volunteer pool, the unpaid workforce helps the agency extend its services and its influence.

## CONCLUSION

As an organizational psychologist, I have spent many hours wondering why this agency has been so successful in treating the homeless elderly population. Of course, many programmatic variables have contributed to Saint Mary's accomplishments, such as providing a safe and supportive environment for the clients, having intensive case management, and offering integrated treatment for clients. In addition, Saint Mary's Center has professionally trained staff, a wide array of support services for clients, and easy access to psychiatric evaluations and medications through services of the on-site psychiatrist. As suggested earlier, these factors are all crucial to effectively serving elderly homeless people with mental health problems.

I believe, however, that the deeply engrained values of social justice, respect for the dignity of the individual, and commitment to meaning-making are the real keys to Saint Mary's achievements. Success with this population is a matter of not only providing multiple services at one site, but also integrating those services within the organization and infusing

within each staff member, regardless of position, a deep commitment to the shared values and mission of the agency. When the staff members and volunteers live out the values of social justice, respect for the dignity of the individual, and commitment to meaning-making, the results are impressive. A substance abuser and self-described loner who was found living in his truck described his personal transformation in this way: "Saint 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." This is but one of the individuals whose lives have been changed by Saint Mary's Center. **HSW**

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