Motivating Housing: A Training Program to Address Homelessness in Hawai'i

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A Clinical Research Project presented to the faculty of the Hawai'i School of Professional Psychology at Chaminade University of Honolulu in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.

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This Clinical Research Project by Joseph Svec, directed and approved by the candidate's Clinical Research Project Committee, was approved by the faculty of the Hawai'i School of Professional Psychology at Chaminade University of Honolulu in partial fulfillment of the requirements of the degree of Doctor of Psychology in Clinical Psychology.

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Abstract

Homeless individuals experience a myriad of difficulties, including threats to physical safety, availability of food and water, and access to necessary services. Society's views of the homeless population have been found to impact the individuals' wellbeing, as well as interfere with their independence when pursuing care and available resources. Thus, through reviewing the phenomenological research on these issues, developing a program to overcome such barriers to treatment and care is paramount. The Motivating Housing training program seeks to provide an evidence-based, culturally-minded approach to care for staff of housing/shelter agencies. Founded on the basics of Motivational Interviewing, Motivating Housing seeks to increase the rates of entry and engagement of available housing programs, as well as promote sustainable housing for those in the homeless community.

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Introduction

Currently, one would be hard-pressed to find a state that's respective metropolitan areas do not struggle with assessing and consequently, effectively treating the issue of homelessness. In Hawai'i, the City and County (C&C) of Honolulu faces specific problems due to its unique size and structure. The C&C's jurisdiction encompasses the downtown area of Honolulu, as well as the surrounding 597-square miles of O'ahu; it has no local municipal governing bodies to whom it may delegate implementation and operation of homelessness-reduction initiatives.

In attempts to manage the issue of homelessness, the C&C enlists state services and local public and private service sectors; this homelessness coalition, composed of public agencies and private organizations include psychologists, psychiatrists, and social workers. The coalition actively works to gain an accurate picture of the scope and span of homelessness in Honolulu with the aim of eventually assuaging this growing crisis.

Sadly, the success of previously implemented plans and programs have largely produced variable results. Some of these programs, while beneficial to those that utilize them, have ultimately encountered the issue of insufficient funding. In many cases, the programs are issued or allocated funding depending upon outcome measure-deemed success in executing their specific purpose. In the case of housing programs, if the services are underutilized or unsuccessful in their goals such as maintaining sobriety of the occupants, providing safe shelter for domestic violence victims, or providing education related to future employment, they are gradually pushed out of existence through a decrease in funding.

Despite the fact that many of these initiatives don't end up achieving the level of financial independence and utility that they desire to be truly self-sustaining and beneficial, their

goals and initiatives are extremely valuable and necessary. Therefore, after an extensive review of the extant literature relating to these issues, it has become apparent that while many available and well-intentioned programs exist, O‘ahu’s homeless population does not properly utilize said services.

Many homeless individuals have expressed their interest in programs that provide safe housing, substance abuse treatment, general hygiene supplies, and occupational preparation/enhancement. However, despite a resounding request for these services, many of these individuals refuse to utilize them. Why? Quite frequently, homeless individuals report upon their distaste for receiving infantilizing language by service providers and ultimately losing their sense of autonomy and independence.

The nature and framework of Motivational Interviewing is that of promoting self-efficacy and one’s own internal locus of control. This model runs counter to the aforementioned notions of infantilization and loss of autonomy experienced by many homeless individuals who have sought support through various programs and services. It is the objective of this program, Motivational Housing, to utilize Motivational Interviewing techniques in order to bridge the gap between beneficial services and participants’ willingness to engage in said programs. Further, through a culturally-minded lens, this program aims to enhance the lives of the homeless population of O‘ahu by facilitating housing service utilization and adherence, while maintaining a low financial overhead. Credentialed individuals properly trained in Motivational Interviewing will assist the staff of currently available programs to effectively alter communication and services to instill an internal locus of control and self-efficacy within the homeless recipients.

Purpose of the Study

The purpose of this study was to develop and implement a program that would increase the utilization rates of various extant homeless housing programs at a low cost. This program aims to increase the rates of utilization of housing programs for homeless individuals, as well as address a multitude of negative byproducts of homelessness. Specifically, the health of individuals in this population is at much greater risk that those who have long term housing—the National Association of State Mental Health Program Directors (NASMHPD) stated, "A landmark report indicated that individuals living with serious mental illness (SMI) die, on average, 25 years earlier than individuals in the general population" (Bonugli, Lesser, & Escandon, 2013, p.827). Interestingly, housed individuals are more likely to engage in medical care through a primary care physician, while homeless individuals are more likely to utilize emergency services (e.g., fire department, ambulance, emergency room) (Wise & Phillips, 2013). Further, a study of individuals who were considered to be at the highest risk for medical issues stated that these individuals made a total of 18,384 ER visits within a single year (an average of thirty times a year per individual), costing approximately $37 million dollars (Wise & Phillips, 2013).

Significance of the Study

The state of Hawai‘i has one of the second largest numbers of homeless individuals per capita in the United States, 487 per 100,000 people (City & County of Honolulu Department of Community Services, State of Hawai‘i Department of Human Services Homeless Programs Office, & Partners in Care, 2019). These individuals suffer disproportionately more than the housed population with regard to economic, health, and safety issues (McBride, 2011). Steps

taken to effectively and responsibly assist this population in obtaining and maintaining housing is a critical step towards improving upon said problems. Once housed, individuals can better establish with primary care physicians, address mental health concerns, continue and/or maintain adequate educational or occupational experiences, overcome substance abuse, and achieve a true sense of autonomy (McBride, 2011).

Additionally, an aspect of homelessness that is too often unaddressed is that of social disconnectedness. The significant impact that this factor has on individuals cannot be overstated, especially within the context of the Native Hawaiian people, as the Hawaiian culture places particular emphasis on community and the concept of *Aloha ʻĀina* or "the love of land," otherwise known as a sense of place.

REVIEW OF LITERATURE

2019 Point-in-Time Study

Due to the ever-changing nature of the island's population, the city of Honolulu employs a point-in-time (PIT) method of measuring its homeless population as well as specific demographics amongst the population. On January 22, 2019, the City & County set out to catalog both sheltered and unsheltered homeless across the island of Oahu. The single-day PIT study revealed that there were approximately 4,453 homeless individuals, 2,052 of which were sheltered and 2,401 remaining unsheltered (City & County of Honolulu Department of Community Services, State of Hawai‘i Department of Human Services Homeless Programs Office, & Partners in Care, 2019). It is important to note that the numbers for unsheltered homeless on O‘ahu, while likely accurate, are only what the team was able to assess with limited

time and resources; assumedly, the numbers for the unsheltered population are higher than those that the 2019 study reported. Despite the imperfect nature of this single-day search, the numbers it yielded are still an invaluable tool for those who seek to gain key insight into the root causes of homelessness.

The results of the 2019 PIT study show a 1% decline in the total number of individuals experiencing homelessness since the year before. This is in contrast to the results of the 2018 PIT results, which had been showing a steady increase in the total homeless population over the past five years. However, the number of sheltered homeless remained relatively constant during this time, peaking in 2013 at 3,091. There has been concerning growth in the unsheltered homeless population, rising by 1,027 between 2010 and 2019. While this data is troublesome, there could be many reasons for the increase in the unsheltered population. As the 2019 PIT results expressly state, "much of the increase in unsheltered homeless is assumed to be due to improved execution of the count," (City & County of Honolulu Department of Community Services, State of Hawai‘i Department of Human Services Homeless Programs Office, & Partners in Care, 2019). It therefore remains unclear whether O‘ahu has in fact experienced an increase, or if the PIT has simply become more accurate in accounting for the total population.

In contrast to the rising number of unsheltered individuals experiencing homelessness is the steady decline of these individuals who are sheltered. Despite some questions as to whether these numbers are due to improved PIT accuracy or not it is clear that the data shows a trend for the worse. A steady decline in sheltered homeless coupled with a steady increase in unsheltered homeless points to problems with finding permanent housing for these individuals.

Specific Circumstances and Issues

The 2019 PIT results are broken down into several categories such as marital and family status. A single person is defined as an "unaccompanied person or a person in a multi-adult household," and a "family" is defined as "members of family households with at least one adult and one child under the age of 18 years of age." As of 2019 there are 2,563 homeless singles, with 35% of them sheltered and 65% unsheltered. Likewise, there are 2,340 homeless individuals living within a "family," with 88% of them sheltered and 12% of them unsheltered (City & County of Honolulu Department of Community Services, State of Hawai'i Department of Human Services Homeless Programs Office, & Partners in Care, 2019).

The most recent PIT study further categorizes how many of Honolulu's homeless individuals suffer from serious mental illness (SMI), substance use disorders, have HIV/AIDS, or are victims of domestic violence. Upon examination of such categories, it is glaringly apparent that SMI is the largest issue facing Honolulu's homeless, with 993 homeless individuals reportedly suffering from one or more illnesses (394 sheltered and 599 unsheltered). Substance use is the second most prevalent issue, with 771 homeless individuals reportedly abusing substances (257 sheltered and 514 unsheltered). HIV/AIDS is the third most common issue, with 48 homeless individuals reported to have tested positive (26 sheltered and 22 unsheltered). The issue of domestic violence is the fourth most common with 249 sheltered individuals, and an unreported number of unsheltered individuals (City & County of Honolulu Department of Community Services, State of Hawai'i Department of Human Services Homeless Programs Office, & Partners in Care, 2019).

The True Cost of the Mentally-Ill Homeless Population

While an estimated 5,000 of a population of nearly 1,000,000 (0.005%) might not seem like an overwhelming amount, the toll that Honolulu's homeless have on their surroundings is financially and emotionally astounding. According to the U.S. Department of Housing and Urban Development, or HUD, on any given night in January of 2010 over 26% of all sheltered homeless individuals across the U.S. had a serious mental illness or SMI (USD HUD, 2011). Additionally, in 2006 the National Association of State Mental Health Program Directors, NASMHPD stated, "A landmark report indicated that individuals living with serious mental illness (SMI) die, on average, 25 years earlier than individuals in the general population" (Bonugli, Lesser, & Escandon, 2013, p.827). Homeless individuals in need of medical care often use a hospital's emergency rooms as their primary care facilities, knowing they must be treated despite their lack of insurance or ability to pay. The National Institutes of Health (NIH) found that a visit to an emergency room costs an average of $2,000 (National Institute of Health, 2013).

The true cost of misappropriated emergency care to hospitals and taxpayers was discussed by Caitlin Wise and Kenneth Philips (2013) in their article, *Hearing the Silent Voices: Narratives of Health Care and Homelessness*. In the article, Wise and Philips (2013) cite a five-year-long study in which a group of 119 "high-risk local 'rough sleepers,' (defined as those who were chronically homeless for longer than six months and who generally avoided shelters)" (Wise & Phillips, 2013, p.319) made a total of 18,384 ER visits (an average of thirty times a year per individual), costing approximately $37 million dollars (Wise & Phillips, 2013). While the people used in this study were more than likely using the emergency room more than any other category of homeless population, they shed light on the true magnitude of the problem.

Overview of Homeless Individuals' Needs

In light of the high prevalence and overwhelming cost that homelessness has on communities around the nation, it is important to delve deeper into the experience of the homeless individual. Specifically, encapsulating how homeless individuals and their health and general-care providers perceive one another is of great importance. Obtaining a better understanding of the struggles that both entities face may facilitate an improved understanding and a higher degree of cooperation between policymakers, service care providers, homeless individuals, and the community at large.

A good way to categorize such needs is to use Abraham Maslow's Hierarchy of Needs (Maslow, 1968). On the bottom of this hierarchy is physiological needs, followed by safety, social, self-esteem, and lastly self-actualization. Maslow stated that it isn't until much later in a person's life that they reach the final stage of self-actualization, and thus the beginning stages are the most common for the general population to undergo, especially for the homeless population (Maslow, 1968). Homeless individuals are often denied or starved of their physiological and social needs, as well as general safety, thus, these domains will be explored further.

Physiological needs

In a study entitled S*urvival on the Streets: Experiences of the Homeless Population and Constructive Suggestions for Assistance*, Rebecca C. McBride (2011) compiled the interview statements of 11 homeless participants in order to gain insight into how participants perceived their needs and how knowledge of these perspectives might enable others to better provide them with assistance. McBride broke down her research into fundamental themes that

arose over and over again as she interviewed the 11 participants. The "met needs" category indicated that the need for food was clearly met (McBride, 2011). One participant even went so far as to say, "I never worry about going hungry" (McBride, 2011, p.54). While this is undoubtedly not true for all of the homeless population, it is important to understand that the ability of the homeless to meet their needs will change based on location and their understanding of how to navigate various social assistance programs. Every state has a range of sources of food, including food banks, churches, and charities (City & County of Honolulu Department of Community Services, State of Hawai'i Department of Human Services Homeless Programs Office, & Partners in Care, 2019).

General Safety

Working our way up Maslow's hierarchy, we reach the need for safety. While all the needs on the hierarchy are important at various stages throughout a person's life, as a homeless individual, safety might be the most critical factor of all. The ability to feel safe, as well as to find an area to rest, serves as an immense roadblock to the homeless. The 11 participants in McBride's study agreed that the primary unmet need of this population was shelter (McBride, 2011). One of the participants spoke of the hardships of not having a place to sleep, "I hide in the dark and sleep under trees, or in abandoned buildings . . . when it doesn't rain, I can sleep under the stars" (McBride, 2011, p.54).

Housing Needs

An article by Kirkpatrick & Byrne (2009) entitled *A Narrative Inquiry: Moving on From Homelessness for Individuals with a Major Mental Illness*, investigated homeless individuals'

perspective of how their needs are being met and what can be done to better assist them. One section of the article discusses the positive impact that housing can have on a homeless person's life, stating that "housing-related issues for homeless people living with mental illness have been researched extensively." Choice in housing has been positively related to housing satisfaction, residential stability and psychological well-being (Kirkpatrick & Byrne, 2009, p.69). Not only does this comment bring up the issue of homeless individuals needing housing in order to change their lives for the better, it also raises the important fact that *choice* in housing is significant. Examining community-provided shelter, impermanence is notable. Some shelters only allow women and children to be housed on site in order to remove them from abusive situations or keep children off the street, however, these places are usually not permanent in nature. Rather than housing these women and families for long durations of time, rules and regulations sometimes require families to leave during the day and return in the evening. Other forms of housing require individuals to proclaim certain religious beliefs in order to receive their services. Some might only allow homeless individuals to stay for short periods of time such as a few days or a week.

While any help is undoubtedly appreciated, temporary solutions seem to be a band aid than a real fix. Some of the housing solutions are better thought of than others. In fact, studies have shown that a more comprehensive form of housing has its benefits—"research demonstrates support for a shift to supported housing, which is defined as permanent housing in the community with supports provided to assist the person to become successful and stay off the streets" (Kirkpatrick & Byrne, 2009, p.69).

Experiences of Violence

Continuing our examination of the need for safety, we turn away from shelter and look at the need to stay away from violence or threatening situations. The amount of violence and trauma that the average homeless individual either sees or experiences themselves is staggering. Research demonstrates that "lifetime estimates of physical and sexual abuse among homeless women with SMI range between 51-97%, leading some researchers to suggest that abuse is perceived as a normative experience" (Bonugli, Lesser, & Escandon, 2013, p.828). Not only is this violence inherently tragic, its deleterious effects can also manifest differently in each victim. There is an ever-increasing body of literature that supports the claim that violence against the homeless population, especially women, is on the rise (Bonugli, Lesser, & Escandon, 2013, p.827). While all homeless are vulnerable to violence while living on the streets, those living with SMI are at greater risk. The repercussions of this violence are not only physical, "the cumulative effects of traumatic experiences can result in a myriad of negative health outcomes, such as increased physical illness, substance abuse, and psychiatric comorbidities" (Bonugli, Lesser, & Escandon, 2013).

Indeed, the prominence and effects that this type of violence can have on any population is disheartening, however, when put into specific context, the true nature of this type of violence comes to light. One homeless participant who was interviewed by Bonugli, Lesser, and Escandon (2013) described how violence had always been a part of her life. She stated, "I had a hatred for my father. He was abusive to everybody, physical abuse, sexual, everything. Especially to my mom, the first thing he'd do is rip off her clothes and he'd just beat her and rape her in front of everybody" (Bonugli, Lesser, & Escandon, 2013, p.830). Exposure to violence severely impacts victims on an individual basis, as well as influences communities and cultures in totality.

Health Needs

The previous sections have illustrated the many physical factors threatening the homeless population; therefore, health is another primary concern for the homeless. On average, the health of homeless individuals is much worse than people from the general population (Seiler & Moss, 2010). As the vast majority of the homeless population is also uninsured, finding medical assistance can be a very difficult task (Seiler & Moss, 2010). A 2008 study by Zlotnick and Zerger (2008) found that "homeless people are far more likely to suffer from every category of chronic health problems, with the exception of heart disease and cancer. The homeless also have higher mortality rates than the general population as well as more frequent respiratory and gastrointestinal ("GI") problems, neurological conditions, and infectious diseases such as tuberculosis, HIV, and pneumonia" (Zlotnick & Zerger, 2008, p.19).

Social Needs

Another set of important and often overlooked needs of the homeless population resides in the realm of social interaction. One of the most commonly expressed beliefs, by those interviewed in the various studies, is that they think they are from a "different world." By this, they mean that they are no longer part of the "normal" community (Zlotnick & Zerger, 2008, p.19); they have become undesirable outcasts in their own eyes, as well as in the eyes of the general public. Altering these perceptions on both ends could have an enormous impact on the general well-being of this population.

In their article, Cornwell and Waite (2009) discuss social isolation in the homeless population. The authors identified two different forms of social isolation. The first is "social

disconnectedness," defined as a "lack of social relations and low levels of participation in social activities," while the second form is "perceived isolation," defined as "a subjective experience of feelings of loneliness and perceived lack of social support" (Cornwell & Waite, 2009, p.42). If an individual in the homeless community feels a strong social disconnect in either of these two ways, their perceptions of isolation potentially serves as an additional barrier to seeking beneficial services.

A study by Pedersen, Andersen, and Curtis conducted in 2012, compiled narratives from forty-five homeless individuals. When asked if he had someone in his life whom he was close to or trusted, one study participant admitted, "I used to have that, but … you know, I wouldn't have thought it, but when you become homeless all of a sudden … well, then everything disappears. Your entire network. It totally breaks apart. So, all those people you thought you could care about . . . they're gone" (Pedersen, Andersen, & Curtis, 2012, p.851). In pondering this individual's perception of his own situation, as well as how society seems to view him, it is easy to comprehend how the motivation for seeking help and services is easily diminished. However, some researchers have found hope in the form of Cognitive Behavioral Therapy aimed at altering peoples' deeply embedded schemas about their social connectedness. A schema is a concept that has been employed by many psychologists and understood through many different theoretical frameworks. It is defined by Butcher, Hooley and Mineka as "an underlying representation of knowledge that guides the current processing of information and often leads to distortions in attention, memory, and comprehension" (Butcher, Hooley, & Mineka, 2014, p.79). Put more simply, it is the framework that people use to make sense of an extremely complex world. People begin to form schemas about themselves, others, and how they can be expected to be treated starting at a very young age (Cruwys et al., 2014).

> Considering particular testimonials from homeless youth, it is conceivable how an understanding that the world is an unfair, cruel, and a dangerous place can begin forming immediately for some of the homeless population. These early maladaptive schemas are especially challenging to alter, and in most cases, operate outside of the conscious awareness of the individual.

Despite their obviously detrimental nature, these schemas often developed purely out of necessity and experience. In the case of the child who had watched her mother be beaten and raped by her father, her schema of "a dangerous world", and "don't trust others," did play an adaptive role for her throughout development (Cruwys et al., 2014). This disadvantaged youth, due to a homelessness-related lifestyle, was undoubtedly around people that caused her a considerable threat; by utilizing these schemas, she might have been better able to survive a life on the streets.

Through the lens of homeless individuals' narratives, one can identify how social isolation is a major barrier for this population, and acts as a hindrance by preventing them from a more positive outlook on life, as well as treatment. Research has shown that these schemas, while deeply embedded, can be modified (Cruwys et al., 2014). Experts argue that "maladaptive schemas are modifiable in short-term therapy or even in community settings" (Cruwys et al., 2014, p. 265).

While the therapeutic aspects of changing these schemas are subtle and nuanced, some of the general factors involved include facilitating the experience of being accepted into any social group or support group and positive social interactions that run counter to their existing schemas (Cruwys et al., 2014). The challenge, however, is that individuals' negative experiences can further confirm these deeply-seeded core beliefs. Thus, when people in the homeless community are treated unfairly by individuals in the community, employees of a care facility, or even by peers, their core schemas are activated and subsequently further solidified.

The General Public's View of the Homeless

The article entitled, "A Narrative Inquiry: Moving on From Homelessness for Individuals with a Major Mental Illness" posits that, "those who are in control in society determine whose stories are important and should be given social value. For those who lack power, community narratives available to them may be negative, narrow, and/or written by others. People with mental illnesses and homeless people face both stigma and discrimination in current society, therefore limiting their voice" (Kirkpatrick & Byrne, 2009, p.69). Highlighting the issue that the current non-homeless, majority population is constructing the social narratives, it becomes easier to conceive that the "best" means for addressing homelessness has become so elusive.

One method of combating this in-group/out-group bias was first introduced by Gordon Allport in 1954. Allport is credited with one of the larger milestones in social psychology—his work on understanding how prejudice between groups developed sparked the creation of the "contact hypothesis." Put simply, the contact hypothesis "posits that in-group/out-group contact, if positive in nature, erodes stereotypes and reduces fear of the other" (Knecht & Martinez, 2000, p.521).

Putting this concept into action, a group of researchers in San Francisco organized an event called Project Homeless Connect (PHC). The goal of PHC was to create an event in which the homeless population are provided with a wide assortment of service information desks to aid them in progressing out of homelessness. In conjunction with the provision of services offered, there was a large number of volunteers, both helping to operate the event, as well as walking around and interacting with the homeless individuals. Therefore, PHC was not only a way to

provide services to the homeless, but also a way to expose those in the non-homeless majority to the world of the homeless (Knecht & Martinez, 2000). Using a pre- and posttest measure, the researchers were able to gauge the attitudes of the volunteers, as well as how the event itself impacted these attitudes. The results of the interaction were stunning—the researchers found that "individuals with the greatest exposure to the homeless people were more likely to believe the problem was caused by structural inequalities, more likely to express compassion toward the homeless, and less likely to view the homeless as threatening or dangerous" (Knecht & Martinez, 2000, p.522).

In pondering these results, it is apparent that a single experience/episode of exposure to this population called most of the existing stereotypes about the homeless population being drug addicts, mentally ill, or dangerous into question. This type of interaction could be the catalyst for change that society needs. By interacting with these individuals more, people might be better able to reflect upon their individual biases, as well as those of the community at large. This would likely greatly change the common perception held by many that homelessness is an issue of choice and that these individuals are completely at fault for their current circumstances.

A study performed by Kooken, Baylor, and Schwend (2013) touches on the issue of social perceptions of the homeless, as well as the mentally ill. Kooken, Baylor, and Schwend highlight that social norms about various out-groups, in this case the homeless, can come from diverse sources and need to be constantly checked for validity and usefulness. They state that "people often rely on what is seen in the media or what they learn through societal norms to make determinations about mental illness" (Kooken, Baylor, & Schwend, 2013, p. 307). The authors also identified the fact that when a person has little knowledge or experience with something, it can often be viewed negatively or with fear. Thus, leading people to avoid this

feared group or concept further prevents them from gaining knowledge about the feared or misjudged population and ultimately providing necessary help (Kooken, Baylor, & Schwend, 2013).

Homeless Women

Perhaps one of the most disenfranchised groups that exist today, homeless women, especially those suffering from mental illness or drug addiction, live with immense degrees of perceived discrimination. In a previously mentioned study, "The Second Thing to Hell is Living under that Bridge': Narratives of Women Living with Victimization, Serious Mental Illness, and in Homelessness," the women in this study were interviewed to gain further insight into the plights that many homeless women face (Bonugli, Lesser, & Escandon, 2013).

The authors encapsulated the experience of living with such intense stigma perfectly by capturing a woman's experiences with different sets of rules. Specifically, the woman stated that "it was like living in a world with two sets of rules, one for the non-homeless population, and one for the homeless population" (Bonugli, Lesser, & Escandon, 2013).

In essence, homeless women live with four separate but powerful areas of stigmatization—they endure stigma associated with mental illness; homelessness; substance use; and lastly, in being a woman. In an excerpt of one woman's comments, she discussed a homeless person urinating in public as opposed to a non-homeless performing a similar act. In her dialogue, she stated that a non-homeless person might not get a ticket for doing so, while a homeless individual might receive a fine that they are unable to pay or potentially face jail time. She added that there could potentially be a consequent discussion about policy change due

to the public nuisance that the homeless population creates (Bonugli, Lesser, & Escandon, 2013).

Perception of Public Service and Healthcare Providers

In considering the ways in which society perceives the homeless population, it is discernible that these assessments serve as roadblocks to receiving treatment, as well as homeless individuals' stagnancy in the social hierarchy. It is common belief that those working in the healthcare field are deeply compassionate and understanding of others' plights. However, due to the often intensely stressful work environment of serving the homeless, those with SMI, as well as those with addictions, burnout and mistreatment are all too common.

A study by Biederman & Nichols (2014) entitled, "Homeless Women's Experience of Service Provider Encounters," utilized the statements of 15 homeless women focused on their experiences at various care facilities. Their statements were analyzed and broken down into thematic categories. Five classes were discovered centering upon the idea of "dehumanization," ranging from *least harmful* to *most harmful*. The categories consisted of *unmet expectations*, *judged*, *minimized, alienated*, and finally, *powerless* (Biederman & Nichols, 2014).

The second to last category, *alienated,* defined by the researchers as "feeling alienated in interactions where they felt disregarded, unwelcome, or like they were a nuisance of a both to the service provider," proved to have particular impact on the women in the study (Biederman & Nichols, 2014, p. 42). Many of the women described these alienating experiences as awful, brutal, and horrible (Biederman & Nichols, 2014). One woman's experience provides a powerful example of how the perceptions of the homeless community bleed into the care individuals receive at facilities. She described being in line for a plate of food at a shelter,

stating, “I went to walk around the other, other side of the table to pick up the plate, you know. I thought that’s the way you did it—[y]ou just went around like buffet style…[a]nd she says, ‘you don't belong here. You don't belong on this side of the counter. We only stay on this side of the counter” (Biederman & Nichols, 2014, p.42).

Comments like this make it easy to see how clearly some providers view the homeless individuals as unequal to or lesser than themselves. These perceptions of the homeless are clearly heard and understood by those in need. While this woman did end up getting food, she went on to describe never going back to that shelter again due to how dehumanizing the experience was (Biederman & Nichols, 2014).

Perception of Homeless Individuals

The article by Seiler and Moss (2010) mentioned previously describes how the service providers’ thoughts and perceptions of the homeless population can restrict their ability to provide adequate services. In this study, they focused on the experience of nurse practitioners (NP) working with the homeless and ultimately identified an NP that offered a possible solution to this very issue. The NP stated, “in essence, I think, just like with any patient, try to empathize with what their life situation is —recognizing our assumptions, our stereotypes, our judgments; recognizing that we have those things, racism or whatever it is, and not carrying that with you” (Seiler & Moss, 2010, p.310).

Ideally, nobody would have these preconceived negative attitudes towards other groups; however, the sad reality is that stereotypes and racially-biased attitudes are prevalent in certain environments. The aforementioned NP’s reflection supports an important and valid point—that it is ethically necessary for providers to identify and effectively manage their own biases and

filters. As the NP stated, be cognizant of your attitudes and focus on aligning yourself with the individual you are serving (Seiler & Moss, 2010).

Thus far, examples of how the general public views homelessness as well as how those ideals can prevent the homeless from receiving the help that they need have been clearly delineated. The next section focuses exclusively on how the professionals in this realm, (i.e., nurses, nurse practitioners, medical doctors, psychologists, and psychiatrists) view this population.

When entering the medical field or human services such as psychology or social work, pessimistic or unhelpful attitudes are assumedly negligible. On the whole, these types of service providers dedicate their lives to help those in need and to fulfill their purpose through humanistic services. In general, this attitude is reflected in the literature that relates to service providers perceptions of those they are treating. An article previously discussed, narratives from NP's delineated a major theme that was dubbed, *making a difference* (Seiler & Moss, 2010). The NP's saw their work as having the potential to make a real difference in their communities, as well as in the lives of the patients by whom they served.

A particular NP's stated, "There's so much need and so much difference that we can make, so I feel like my efforts reap so much reward" (Seiler & Moss, 2010, p. 307). Several of the participants in the study shared this idea, feeling as if there was a great need and that their work can really make a difference. Some of those interviewed stated that it was their mission and/or that they were fulfilling a deeper calling (Seiler & Moss, 2010).

While these comments seem to be an example of the positive views of those providing care to the homeless and SMI populations, it could be a metaphorical double-edged sword. Simply, by viewing the aforementioned groups as "in need" or by referring to their

positions as fulfilling a "deeper calling," the NPs might be unintentionally distancing themselves from the groups. In other words, in viewing those in need as so far from one's self or as the out-group, one might also be putting themselves *above* this group. This perception discrepancy in social status could lead to unfair treatment or infantilization of the out-group.

Thankfully, some of the NP's addressed this issue by stating that it is important to do one's best to make a true connection with patients in order to serve them properly. In some cases, this population lacks almost any semblance of a positive social connection, thus, making these types of attitudes all the more important. Most of the participants in this study had similar thoughts on maintaining connections with their patients stating that the "complexity of providing health care to the homeless and the devastation of mental illness and substance abuse and how that leads up to the severing of ties with their family and friends." Participants referred to this in several ways as "the disconnection, another as the downward spiral, and another as a lifetime of happening" (Seiler & Moss, 2010, p.307). Due to the fact that these individuals might not have many positive social relationships, the NP's also stated that developing these types of close provider-patient relationships can be much more difficult than serving the general population (Seiler & Moss, 2010).

An additional prevalent theme expressed by care providers was frustration over the differences in priorities between them and their patients. Not surprisingly, those providing services to the homeless and SMI populations would want their health and mental stability to be top priority. However, for many, it is not. This is where Maslow's Hierarchy of Needs once again appears.

> I really can understand how your health is not, necessarily, on your top priority list when you're thinking about housing or jobs. I mean, Maslow's hierarchy really comes into play in dealing with the homeless, and it can be a pretty frustrating experience when, you know, they come in and they've admitted to not taking their medicines, or they've lost

> their medicines. You know at times, you find yourself frustrated with them, and then you remember, that's not their priority, that's my priority (Seiler & Moss, 2010, p. 308).

This NP's quote about the importance of meeting one's needs is paramount when attempting to work with an often-difficult population. This is, once again, why it is so important to have an understanding of what difficulties the homeless community face; by increasing our knowledge, one can not only provide this population with things that they need, but also better prepare themselves to serve.

Having discussed schema-focused therapy, we know that there are ways to reduce our negative thoughts about ourselves and others. Exposure to groups that you have little experience with can be a great way to begin this process. This is one of the many reasons that most programs designed to educate healthcare professionals often have a rotation of exposure to at-risk populations. The study by Kooken, Baylor, and Schwend (2013) took advantage of a program and did a pre- and posttest examination of the NP's perceptions of the homeless. In order to do this, the authors of the study utilized art as a way of gaining knowledge of their perceptions.

In both the pre- and posttests, participants were asked to draw a picture in response to the question, "How far apart are you from these men?" (Kooken, Baylor, & Schwend, 2013, p. 306). This form of information gathering sought to examine the natural power differential that exists between health care providers and their patients; a power differential that is multiplied when working with the homeless or mentally ill (Kooken, Baylor, & Schwend, 2013). What the researchers in this study identified was that the drawings prior to clinical interaction were usually black and white or monochromatic and participants also often drew themselves as larger than their homeless counterpart. They also situated themselves above the homeless individuals, as well as far apart in distance from the homeless. They also often used labels such as "me" and

"them," in addition to giving themselves much greater detail in their figure versus a mere outline of a homeless individual (Kooken, Baylor, & Schwend, 2013).

The illustrations done following the participant's interactions with homeless individuals were drastically different. In the post-clinical drawings, two major themes came to light, "discovering common bonds" and "magical journey." The pictures drawn by the students after the clinical interaction with the homeless and mentally ill patients showed both the student and the homeless individual on the same plain of existence, often right next to each other. Other noteworthy changes were greater detail drawn into the faces and bodies of the homeless individuals. The authors of this article go on to describe the changes the students underwent stating, "Students discovered that their initial perceptions were based on limited life experiences and the clinical experience created a new way to perceive the clients" (Kooken, Baylor, & Schwend, 2013, p. 310). In line with the notion of positive interactive experiences being able to alter one's schemas about various populations, this article demonstrated that knowledge and experience working with this distant population were able to change some of the stigmatized views of the homeless and SMI populations (Kooken, Baylor, & Schwend, 2013).

Many of the articles and information that has been discussed thus far provides insight into how the homeless are treated and understood through their interactions with service providers. This section will focus exclusively on how the homeless and mentally ill perceive the care they are receiving. In the extant literature, there are two main categories of communication styles that surface repeatedly—infantilization and objectification. This is evidenced by the reports of several previously mentioned authors, Hoffman and Coffey (2008), Biederman and Nichols (2014), Bonugli, Lesser, and Escandon (2013), and Zerger et al. (2014). Understanding

that these two themes are identified as salient throughout several different studies highlights that the homeless and SMI populations have to overcome societal and emotional barriers. On top of these two commonly identified categories of communication, the vast majority of the research based on narratives of the homeless describes their encounters with service providers as negative. In the studies that did identify positive aspects of these types of encounters, it was only a very small proportion of their results (Biederman & Nichols, 2014).

In one of the studies mentioned previously, the homeless women documented how pervasive the judgment of others can be, stating, “Participants described feeling pigeonholed into the negative stereotype of homeless or their past, not considered an individual, and denied the opportunity to change” (Biederman & Nichols, 2014, p. 41). One participant in this study described her experience of this judgment in an interaction with two police officers in which they were shocked that her response to them telling her she couldn't sleep on the sidewalk was to ask them if they knew of a shelter she could go to, and that she didn't want to be sleeping on the streets. Their initial thoughts of her being mentally ill or using drugs was quickly called into question with her logical and help-seeking response.

Another aspect of the judgment that the homeless routinely experience was depicted by a woman who, at first glance, did not appear to be homeless. She explained that simply because of her appearance, she was denied food and clothing. The woman also identified that she felt constantly under surveillance by those providing assistance per their scrutiny and censure. This type of judgment further supports the notion that homeless individuals experience severe judgments that limit their access to beneficial services. Additionally, if they do not seem to qualify certain “criteria” such as outward appearance, they risk being denied help all together.

An additional female participant discussed her perception of being followed by facility staff members, even when smoking a cigarette outside the facility. This type of hypervigilance demonstrates infantilization due to the fact that the staff seem to operate under the pretenses that the recipients of their facility are unable to monitor themselves and consequently require constant supervision, even when off company grounds.

Finally, and perhaps most shocking, the participants of this study argued that they needed to conceal any past success or positive aspects of their lives for fear of harsher judgment and/or punishment. Some hid the fact that they had a college education, while others hid the fact that they were nurses while receiving medical attention from a currently employed nurse. Biederman and Nichols (2014) found that, "A homeless woman described a negative interaction in an emergency department where she felt the staff were not adequately managing her blood pressure, but she was afraid to reveal that she too was a nurse" (Biederman & Nichols, 2014, p. 41). In addition to having to hide these positive aspects of one's self, these individuals' past challenges and difficulties were highlighted and exploited. For example, a woman spoke of being verbally harassed by a care provider for taking pain medication as prescribed due to her past history of drug abuse (Biederman & Nichols, 2014).

These depictions of real-life experiences, especially by women, display that there is no "correct" way to live as a homeless individual. If you appear too clean or too reasonable, you risk being denied services or treated as if you are trying to take advantage of service providers. Alternatively, if you appear uncleanly or suffer from a stereotypical condition that typically accompanies homelessness, such as drug addiction or mental illness, you are permanently treated as such. Both positions delineate the ongoing hierarchy of homelessness whereby these individuals fall below the non-homeless populations. Biederman and Nichols

highlight this notion very succinctly by stating, “Women felt they had no voice, had no privacy, were infantilized, or felt exploited. In many instances, women felt the inability to advocate for themselves within a situation or lack of action when they attempted self-advocacy” (Biederman & Nichols, 2014, p. 42).

These experiences have been recognized and documented by other researchers. Specifically, Bonugli, Lesser, and Escandon (2013) found similar attitudes amongst their participants. They wrote that, “although the women agreed that shelters were necessary, they thought some of the shelter practices were demeaning. For instance, waiting in long lines, searches upon entry, having to leave before dawn, and lack of privacy often made the women feel devalued. Within the shelters, the women often felt disrespected by shelter staff” (Bonugli, Lesser, & Escandon, 2013, p.832).

When groups of people are treated negatively, as the homeless population largely has, many persecutory attitudes start to develop. In a study that was previously mentioned, “Survival on the Streets: Experiences of the Homeless Population and Constructive Suggestions for Assistance” (McBride, 2011), an individual’s comment illustrates how negatively the “outgroup” can be viewed: “It boils down to one thing: [p]eople are willing to help an animal before a human being, they are forgetting one thing: [t]hat they are just a paycheck away from being out here their damn selves” (McBride, 2011, p.57). With attitudes this harsh, it is easy to understand how difficult it might be to break down these attitudes and perceptions, as well as reduce the number of barriers standing in the way of seeking necessary services.

While the amount of documented positive experiences with service providers is much smaller, it does exist. The article by Biederman and Nichols describes one of the positive aspects of a good service provider encounter as being “cared for.” Some of the words used to describe a

service provider that fit into the category were “listening, talking, giving advice, being available . . . showing concern, joking, giving tangible aid” (Biederman & Nichols, 2014, p.43). By being “cared for” the women of these shelters were able to develop more intimate and trusting relationships with their service providers. This in turn leads to more positive experiences on both ends and allows for the homeless to open up and begin talking about their own specific needs (Biederman & Nichols, 2014). Sadly, the women of this study described these types of interactions as rare, they went on to say that “some women described feeling cared for as ‘surprising’, some were ‘overwhelmed’ at times” (Biederman & Nichols, 2014, p.44).

These types of encounters can have several consequences on the homeless population. One of which is that they completely avoid these types of places or services. While they still undoubtedly need these services, the experience of receiving them is so horrible that they avoid services altogether. Indicated by the findings of Seiler and Moss in their article T*he Experiences of Nurse Practitioners Providing Health Care to the Homeless* many homeless individuals experienced the drawbacks of service providers so severely that they prolonged seeking serves to such an extent that many of them experienced crisis and had to utilize the E.R. (Seiler & Moss, 2010).

This is an example of how the very thing services providers are trying to prevent, providing the homeless with the care they need prior to it becoming an emergency, is actually being caused by their own institutions. Understanding what the homeless populations want and need out of these providers is paramount to creating a working system of care. In addition to avoiding some of these service providers due to the negative baggage that comes along with it is the fact that some of these homeless individuals internalize the negative attitudes and ideas that are forced upon them by the derived providers.

An article by Kooken, Baylor, and Schwend (2013) describes this point beautifully stating, “because persons who are homeless and mentally ill know when they are being stigmatized, they often internalize the negative perceptions. People who are homeless perceive that others do not understand them, see them as a burden, and deserve what they get . . . when they are stigmatized by healthcare providers, including nurses, they experience negative emotional consequences such as shame, withdrawal, and self-isolation” (Kooken, Baylor, & Schwend, 2013, p.307). This is yet another example of why finding the proper way to serve the homeless is of the utmost importance. There can be so many negative consequences to the improper treatment of these individuals that only serve as further barriers to treatment.

While many studies highlighted the negative aspects of poor service providers, two articles did address the positive. One of them was an article entitled *Experience of Primary Care among Homeless Individuals with Mental Health Conditions.* This article identified several factors as indicators for positive experiences of care. They stated, “the following factors predicted positive care experiences: homeless-specific tailoring, perceived extent of choice in providers, and housing status” (Chrystal et al., 2015, p.9). It might seem obvious that homeless specific care would be beneficial to this population. However, many of the service providers operate according to a general practitioner model. This type of operation sets up guidelines that are inherently discriminatory towards the homeless population. One’s ability to comply with medication administration or being on time to appointments is inherently harder for the homeless population than the non-homeless population, among other things.

The ability to choose between different services leading to a better experience with service providers could be due to several factors. One of them being the health care consumer has the option and opportunity to select their own service provider, rather than an agency making

this determination on their own volition. The second possibility is that when one feels that they have a choice in their own care, which fosters an improved sense of self-efficacy; this allows for the consumer to respond to treatment with less hostility.

While the vast majority of the information of the perceptions that the homeless population has on the care they are provided is negative in nature, there are those organizations and individuals who successfully navigate the tumultuous waters of serving the homeless population and provide care in a positive and constructive manner. One participant from a study by Pedersen, Andersen, and Curtis said, "[t]hey take care of me . . . they are the people I know, and they know me . . . if there are things that I don't know how to handle, well, then my contact person knows, and I'll say, 'what do we do here?' That comforts me and puts me at ease." Yet another participant described her service provider as "my confidante, she's really nice. She works with her heart, too . . . not much for the money . . . and she wishes me all the best, I'm sure of that" (Pedersen, Andersen, & Curtis, 2012, p.847). When both parties are pleased with where they are and what is happening a true difference can be made, and it is seen through the attitudes of these grateful individuals.

In order to facilitate long term positive changes in the lives of those suffering from homelessness or mental illness, the issue needs to be addressed from multiple levels. Previously we have discussed how the views of those both within the homeless and SMI group and outside of the homeless and SMI group can affect their treatment, for the better and for the worse. We will now look at how the policies of the local and federal governments, or lack thereof, help to facilitate this change.

The first large scale federal act to better the lives of the homeless population came in 1987 with introduction of the McKinney-Vento Act. The Act itself comprised a range of

programs that affected the homeless population, mainly children. These programs consisted of housing assistance, educational guarantees, nutritional guarantees i.e. free school lunch, and many other aspects that focused on improving the lives of the homeless (Mohan & Shields, 2014).

Of particular interest is its effects on the lives of homeless children, whom the Act defines as, "children and youths who are sharing the housing of others due to loss of housing, economic hardship, or a similar reason; who are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; who are living in emergency or transitional shelters; who are awaiting foster care placement; who have a primary night-time residence that is a public or private place not designated for or ordinarily used as a regular sleeping accommodation for human beings; or who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings" (Mohan & Shields, 2014, p.190).

While this quote is long-winded, it bears an important significance on the issue of homelessness for several reasons. The first being that it is the definition that many scholars have used to define a homeless child since its implementation in 1987. The second reason is that it goes to great lengths to describe every substandard and unacceptable setting in which children are subjected to living. This definition gives the readers a true understanding of the breadth of the issue at hand.

One of the many aims of the Act was to better the educational lives of homeless children. It did this by utilizing many different avenues in order to comprehensively address the undereducated and underserved homeless youth population. Some of the aspects that it focused

on were enrollment, attendance, academic success, and nutritional needs (Mohan & Shields, 2014).

One of the main issues with this idea was that a homeless child would often not identify themselves as such, or even bring up the fact that they were not receiving some of the benefits of a free education that others were allotted. On the other hand, children with parents who were active in their educational needs would be addressing the principles or addressing the schools in order to get their children whatever service they needed. The homeless children, while some had loving parents, most often don't have a social and educational advocate.

This is one of the main reasons that the government decided that every local educational agency designates a staff member to be a McKinney-Vento liaison. These individuals were tasked with identifying homeless children and youth in order to ensure that they "have a full and fair opportunity to learn . . . further under the Act, homeless children are automatically eligible for free meals at school and cannot be excluded from any enrichment programs or supplemental services" (Mohan & Shields, 2014, p.191).

Despite this comprehensive legislation, the homeless children are still massively underperforming in school when compared to their non-homeless counterparts, "less than one quarter of homeless elementary school students are proficient in math (21.5%) and reading (24.4%), as opposed to over one-third (39.6% and 33.8%, respectively)" (Mohan & Shields, 2014, p.191).

The difference in these competency numbers is no doubt due to several factors. First, the living stress of these children is most likely much lower than those children who live in a stable household, the travel time of time that they have to rest and or do work is also likely to be much smaller compared to children living in a household. Another factor is their nutritional health:

despite getting free school lunches, there is no guarantee that children are also getting good nutritious meals at home, and during school vacations. Yet another factor is the social stigmas that these children have to deal with on a daily basis. The adults of the homeless world have to overcome these powerful stigmas as well, however, the children of this population might be more susceptible to ingraining the thoughts of others into their self-concept. This could lead to long term and difficult to alter perceptions of one's self that serve to keep them down and prevent them from progressing out of their tumultuous lives.

As discussed previously in this paper, the ability to choose between health care providers was a major component of a homeless individual's satisfaction with their care. This concept can be extrapolated to the idea of not housing as well. The article entitled *Experience of Primary Care among Homeless Individuals with Mental Health Conditions,* touches on this aspect. (Chrystal et al., 2015). In the article they state that "patients' perceived ability to switch providers on demand is the strongest predictor of primary care experience" (Chrystal et al., 2015, p. 9). This article demonstrates that when a homeless individual perceives that they have no choice in their own life, i.e. health care, then their perceived experience of that care is lowered. Therefore it is not a stretch of the imagination to see how when someone has no say in their own educational setting, their own housing, or who their school liaison is, that they would perceive their own situation in a more negative context (Chrystal et al., 2015).

Research on the issue of homelessness and their experiences of care and treatment has also identified several programs or aspects of good programs that need to be utilized more often than they currently are. The idea of schema therapy that was previously discussed is one avenue to providing better services for both adults and children in the cycle of homelessness. In the article "Social isolation schema responds to positive social experiences: Longitudinal evidence

from vulnerable populations," the authors discuss how changes in one's schemas can occur in several ways; both in the context of a therapeutic intervention, but also in a positive social atmosphere where one can identify with others in the group as being similar to them (Cruwys et al., 2014).

This idea, if implemented properly, could be used to serve both the homeless youth population as well as the homeless adult population. By creating more services that emphasize a positive cohesion of group similarities, such as sports interests, similar social backgrounds, similar family units, or similar life struggles these services could serve to eliminate or reduce the negative schemas that these individuals face. As the authors posited, "some positive experiences, such as identifying with a social group, may be sufficiently powerful to initiate schema modification. These results suggest that social interventions beyond the therapy context, such as those carried out by social workers and community health workers, may have a role to play in reducing maladaptive schemas" (Cruwys et al., 2014, p.276).

Further, research by Ashforth & Kreiner, as well as Haslam, Eggins, & Reynolds suggest that by placing the blame on socially constructed schemas, as opposed to the individual's personality, there is less harm posed to the individual's psyche. These researchers stress the fact that it is important to convey the etiology of this pathology in terms of the social and environmental factors as opposed to the personality factors (Ashforth & Kreiner, 1999; Haslam, Eggins, & Reynolds, 2003). This approach to schema change places less blame on the individual, while simultaneously providing a caring and welcoming therapeutic atmosphere for the homeless individual. Alleviating the possibility of blame being placed on oneself is a major benefit to the homeless individual who is all too frequently confronted with blame and negative perceptions by others.

Another component that is lacking in most states is the availability of housing for the homeless. While there are many different services available to the homeless that provide food, clothing, medical care, as well as temporary housing, there are very few programs that provide permanent and feasible housing. One program that began in 1999 in Ontario, Canada did just that, by providing housing using the Housing with Outreach, Mobile and Engagement Services model. For individuals with a history of homelessness and mental illness, this program provided safe, secure, and affordable housing and a comprehensive array of support services and staff available 7 days a week with 24-hour emergency service" (Kirkpatrick & Byrne, 2009, p. 69-70). The province of Ontario paid $2,000,000 in order to construct these facilities and expected to house around 1,000 individuals. The program offered a variety of housing options ranging from single room occupancy to group units.

While the expense of these types of facilities would undoubtedly be an issue, however, when considering the cost of providing both emergency and non-emergency services to the homeless population, as well as the proven benefits of providing a choice of housing options as well as a choice of service providers, the efficacy of these types of programs begins to show itself. Providing ways for the homeless population to stabilize itself in a dignity preserving manner is a proven way to lower the costs of serving this population (Kirkpatrick & Byrne, 2009).

Those that were lucky enough to be able to participate in this free housing had nothing but good things to say about it, one man had this to say about it "Gary wanted to send a message to the government about how wonderful HOMES is, that such programs should be available for individuals in similar situations" (Kirkpatrick & Byrne, 2009, p.73). The success of this program was attributed to the open-minded approach that its founders had. They did not create an idea

that would only serve one single aspect of the homeless population's needs, rather they sought to create an idea that would be able to tailor itself to each individual. "Rather than narrowly focusing on the illness, a critical question to ask is, what is this person recovering from and who might I help them in that journey?" (Kirkpatrick & Byrne, 2009, p.74). This type of philosophy has truly lent itself to creating a functioning way to assist the homeless out of their plight in a more permanent manner.

Puttingg it together

In reviewing literature on how the homeless community views the care they are being provided with, as well as how those providing the care feel about the homeless, sheds a lot of light on how the issue of homelessness is being addressed. Overall, there seems to be a general dissatisfaction with the services that the homeless are receiving. Numerous studies by Kooken, Baylor, & Schwend, 2013; Mohan & Shields, 2014; Pedersen, Andersen, & Curtis, 2012; Kirkpatrick & Byrne, 2009; Biederman & Nichols, 2014, all reference that there is more dissatisfaction with the services that they receive than satisfaction.

One of the areas that the homeless see as having the biggest deficits is the way in which they are communicated to. Across three different articles authors identified that infantilization and objectification were the two of the main communication styles that were being used (Mohan & Shields, 2014; Bonugli, Lesser, & Escandon, 2013; Zerger et al., 2014). These two methods of communication served as huge barriers to treatment for the homeless and SMI population. Many homeless stated that they would rather go without said service if it meant that they didn't need to deal with mistreatment. Knowing this, it is important to use this information in order to better our ability to provide the homeless with resources they need to escape their situation. Taking this information and presenting it to various care providers in the community

in a clear, succinct, and educational manner could improve the overall experience of attending one of these facilities.

Another way to use this new information to improve our ability to serve the homeless would be to focus on funding educational exposure of service providers to the homeless and SMI population. Knecht & Martinez studied the effects of exposing nurse practitioners to the homeless population in their study entitled *Humanizing the homeless: Does contact erode stereotypes?* In their research, they concluded that exposure to the homeless community was linked to a reduction in negative beliefs and preconceived stigmas about that population (Knecht & Martinez, 2000). This research is yet another call to action: by utilizing this information in the right way, government programs can focus on positive exposure of the in-need population, the homeless, to the general public as well as service providers. Focusing on reducing negative views of the general public as well as service providers might serve to alter how people choose to donate their time and money to the cause. Knecht & Martinez study also found that by exposing people to the homeless population they "were more likely to believe the problem was caused by structural inequalities, more likely to express compassion toward the homeless, and less likely to view the homeless as threatening or dangerous" (Knecht & Martinez, 2000, p.522). Altering our attitudes on the issue might be a better solution than simply giving more money to organizations that have as fundamental a flaw as negative views of the population as a whole.

Lastly, the literature has shown us that when people are given the chance to maintain self-autonomy or perceive that they have a choice in their own lives and their own care, that they respond much more positively to the services they are being provided. Most of the services that exist today only do so if you follow the countless guidelines and stipulations that they very

rigidly require, such as curfews, religious affiliations, no males on site, and sober living. In reality however, research indicates that when people are allowed to be their own individual and maintain choice in their lives, they respond better to treatment. Kirkpatrick & Byrne investigated this issue in their study on the HOMES program in Ontario, Canada. The HOMES program was a form of housing first that provided people with a sense of self and autonomy. The HOMES program should serve as a model for future programs whose aims are to permanently keep people out of homelessness. By empowering people to be able to care for themselves, many other emergency and costly services might be less burdened by the homeless community. Funding programs like this would allow us the peace of mind that the money we are spending on the issue is actually being spent wisely and causing a real difference in the community.

Motivational Interviewing

Motivational Interviewing emphasizes the importance of encouraging self-efficacy, largely pertaining to clients' health and behavior changes (Miller & Rollnick, 1991; Miller & Rollnick, 2002). As has been described by psychologist, Albert Bandura (1986, 1997), self-efficacy is a person's understanding of their ability to use behaviors required in order to achieve a certain outcome, it shows a person's certainty in controlling their personal incentive, action, and collective surroundings (Bandura, 1986, 1997).

MI interventions, notably ones that utilize "assessment feedback," or motivational enhancement therapies (MET), are well recognized as being efficacious in treating drug/alcohol issues in various meta-analysis (Hettema, Steele, & Miller, 2005; Burke, Arkowitz, and Menchola, 2003; Vasilaki, Hosier, & Cox, 2006; Dunn, Deroo, & Rivara, 2001; Britt, Blampied,

& Hudson, 2003; Miller & Wilbourne, 2002). Previously performed studies show that MI increases commitment, remembrance and outcomes when used in conjunction with previously established drug and alcohol treatment programs (Wain, Wilbourne, Harris, Pierson, Teleki, Burling, & Lovett, 2010). Carroll, Libby, Sheehan, & Hylan (2001) found that clients/participants entering outpatient treatment for substance use exhibited improved treatment engagement upon receiving a clinical interview provided through the lens of Motivational Interviewing, as opposed to those who got a typical clinical interview.

With regard to the most severely "dependent" populations, Motivational Interviewing has been less frequently evaluated (Wain *et al.*, 2010, p. 114). Furthermore, there is dispute within the research about how efficacious short interventions, such as MI, are in more acute groups of people. For example, Moyer, Finney, Swearingen, and Vergun (2002) performed a cross study comparison of short interventions that has conditions involving groups of non-treatment pursuing samples, which found that results were more significant if those with the most significant substance issues were removed. However, utilization of MI has also been found to produce favorable results.

Bien, Miller, & Boroughs (1993) showed the strength of a one-hour period of MI with individuals at the VA who had alcohol use issues whose recipients displayed improved results on a measure assessing number of drinks, highest BAC, and number of days without drinking. Similarly, Handmaker, Miller, and Manicke (1999) assessed the effectiveness of blood alcohol levels in pregnant women. They found that those who received a one-hour session of MI demonstrated a larger effect than those that did not receive such intervention. In a study conducted by Martino, Carroll, Nich, and Rounsaville (2006) geared toward individuals diagnosed with psychosis, a two-session MI intervention served to improve outcome results with

those experiencing cocaine use disorders, however, these results were not seen in marijuana users, as was observed in the standard psychiatric interview (Martino, Carroll, Nich, & Rounsaville, 2006).

In a study conducted in 2010 (Wain, Wilbourne, Harris, Pierson, Teleki, Burling, & Lovett, 2010), the authors sought to investigate whether a single session of Motivational Interviewing, without feedback during the screening process, could facilitate meeting waitlist requirements, increase program entry, and support program retention in a population of homeless veterans. They were interested in whether this brief intervention would (1) lower obstacles to enactment that multiple sessions, **(2)** how long feedback might present when working with a ever moving group as well as while beginning continuous treatment.

Wain *et al.* (2010) hypothesized that the intervention would "increase program admission," "length of stay," and "completion and graduation". The authors detailed the extensive research surrounding Motivational Interviewing and substance use treatment, which sought to support their hypothesis. With regard to method, they recruited individuals from the Homeless Veterans Rehabilitation Program (HVRP) of the VA Palo Alto Health Care System (VAPAHCS) in Palo Alto, California. HVRP is a 180-day, program for veterans that are homeless. Those that are housed within the facility are homeless, use substances, and are largely unemployed and experience problems with social functioning.

Seventy-five eligible participants were placed on a wait-list and then utilizing random assignment, were placed in one of two groups, one session of MI (n = 41) or a standard interview (n = 34). Both groups received the same self-report measures to assess readiness and self-efficacy. This process was preceded by follow-ups, either MI or standard intake. Both interview styles were concluded with four questions regarding their duration of unemployment,

alcohol/drug use, living situation, and finally by the length of their period of sobriety. After this, participants were provided with another measure assessing their current status.

While the standard interviews were conducted as a traditional intake session with regard to gathering information about medical issues, prior treatment, and symptoms, personal, and social history, and so forth, the MI interviews were built to assist these individuals in alleviating ambivalence about beginning this program. The interviews were based on a treatment manual developed for the authors' study, which was adapted from the MI treatment principles listed in the Project MATCH Motivational Enhancement Therapy treatment manual (Miller, Zweben, DiClemente, & Rychtrik, 1992).

The initial section of the interview session addressed the "pros and cons of substance use, ambivalence about substance use, how challenges had been overcome in the past, and the discrepancy between the consequences of past behavior and current goals" (Wain *et al.,* 2010, p. 115). Secondly, the interview examined how starting this program was associated with "achieving the stated goals, obstacles that might prevent the participant from achieving those goals, and how said obstacles might be overcome" (Wain *et al.,* 2010, p. 115). Next, participants' "personal strengths" utilized to overcome obstacles were elicited, as were their aspirations for the future, highlighting goals and statements about change. Finally, sessions were concluded with a discussion about readiness, confidence, and the importance placed on entering treatment (Wain *et al.,* 2010, p. 115).

Overall, no significant between-group differences were observed for interview length and number of substances used. The MI interview group had a 95% rate of entry (39/41), which was significantly higher than the 71% program entry rate (24/34) observed in the standard group. With regard to length of stay, the MI group remained in the program longer than the

standard group. However, the difference between the two different groups was not found to be clinically significant. Although there was no significant between-group difference in completion rates, 56% of the MI group completed the program (23/41), while 29% of the standard group completed (10/34). No between-group differences were observed with regard to change in readiness scores; both stayed in Contemplation stage. Lastly, the authors looked for difference between the groups and within the groups with regard to self-efficacy. They did not find a difference between groups n the change of mean scores via the Situational Confidence Questionnaire (SCQ) (Annis & Graham, 1988). However, they did find a significant difference within the two groups, showing an increase in the overall SCQ scores when looking at the before and after interview group, however, this was not seen in the standard group.

The authors noted an important limitation for this study—their sample size was rather small. A small sample size serves as a limitation, as a larger sample size could serve to demonstrate whether insignificant increases in these several factors truly had an impact or not.

Wain *et al.* (2010) contributed to the extant literature centering upon Motivational Interviewing as an intervention tool for homeless veterans and those suffering from substance use. Although much of their analyses determined correlations as being not significant, they did find a significant relationship between a single session, without feedback MI interview and increased program entry. This is very important, as it may provide evidence that the brief sessions of MI can be useful for the most impaired individuals in the study.

Implementing Motivational Interviewing to Reduce Attrition Rates

A 2019 study conducted by Torres, Frain, & Tansey, sought to investigate the effect that training vocational rehabilitation counselors in MI techniques would have on their efficacy as counselors, as well as their clients' ability to return to work. Due to the fact that these

individuals often have opposing views of their own ability and desire to return to work, MI is the perfect candidate for resolving these different viewpoints. Miller and Rollnick state as much in both of the latest editions of the textbook on MI, noting that reconciling competing ideals is a strength of MI due to its ability to promote and utilize one's own internal locus of control (Miller & Rollnick, 2013; Manthey, Jackson, & Evans-Brown, 2011; Wagner & McMahon, 2004). MI has been shown to have a multitude of positive effects, not just on those that are the recipients of the intervention, but those that have learned to implement it as well (Torres, Frain, & Tansey, 2019). Two of these benefits include viewing those that they are working with through a more positive lens and feeling more confident in their ability to help due to having concrete interventions to implement (Torres, Frain, & Tansey, 2019).

The aforementioned study had three specific research questions in mind. Firstly, they wanted to know "if MI counselor training impacts rehabilitation counselors' perceived MI competence." (Manthey, Jackson, & Evans-Brown, 2011; Wagner & McMahon, 2004). The data showed that the training had a significant positive impact on this measure. Secondly, they wanted to know if the training "impacted clients' perceived working alliance." (Torres, Frain, & Tansey, 2019). Again, they found that training in MI significantly improved the working alliance between the client and the counselor. Lastly, researchers wanted to know if the training had an impact on the clients' participation in the vocational rehabilitation services. They found that the clients of counselors who had been trained in MI had significantly more participation in vocational rehabilitation services than those whose counselors had not been given the training (Torres, Frain, & Tansey, 2019).

The results of this study are significant for a multitude of reasons. When viewing them through the perspective of implementing MI training to improve the utilization of and retention

rates related to housing services for the homeless population of Oʻahu, we can see the potential impact it could have on those providing the service and those receiving the service. Looking at the common attitudes of the homeless population related to these services, as well as how they view those providing the services, we see overwhelmingly a feeling of infantilization. The previously mentioned study has shown that by implementing MI training for those who work with individuals who feel like they are being "controlled" or a lack of internal locus of control, we can alter this perspective for the better, increase the retention rates of these programs.

MOTIVATING HOUSING: A MOTIVATIONAL INTERVIEWING TRAINING PROGRAM FOR HOMELESS OUTREACH AND HOUSING PROVIDERS

Theoretical Foundations

The theoretical foundation for the Motivational Housing program aligns with the literature related to Motivational Interviewing, as well as with the findings of the literature related to the problems that are experienced by the housing programs available to the homeless community of Oʻahu, specifically with regard to infantilization and objectification.

The extant literature supporting the theoretical underpinnings of Motivational Interviewing is robust. This is both due to the efficacy of the technique itself, as well as the myriad of situations and conditions that MI is used in. As has been discussed in the previous chapter, MI has been shown to improve one's sense of self-efficacy and internal locus of control (Torres, Frain, & Tansey, 2019; (Miller & Rollnick, 2013). As has been stated in several articles Hoffman and Coffey (2008), Biederman and Nichols (2014), Bonugli, Lesser, and Escandon (2013), and Zerger et al. (2014), the main dissatisfaction with the housing programs is that they

are seen as infantilizing and rejecting the autonomy and self-efficacy of the individuals that participate in them. Therefore, Motivational Interviewing is the perfect tool to combat this type of aversive reaction from the homeless community to the housing programs.

The general assumption of the Motivational Housing program is that the essence of Motivational Interviewing runs in opposition to the feelings of infantilization and objectification. By training the individuals that run these facilities in Motivational Interviewing, there will be two distinct areas of benefit: First and most notably, there will be a reduction in the view that by participating in a housing facility, you are essentially losing your autonomy and self-efficacy. Secondly, the individuals that are working at these facilities, whom have notoriously high burnout rates, will be reinvigorated, both in their ability to provide a useful service to people, and by instilling in them a more positive view of the individuals who are receiving their services (Torres, Frain, & Tansey, 2019).

Assumptions of Motivating Housing

The assumptions of Motivational Housing reach beyond the specific housing programs that it was designed to assist. It is not simply these programs themselves that are having difficulty with assisting individuals within the homeless community. The state of Hawai‘i is spending large amounts of money to fund these programs, as well as many other avenues to assist the homeless community. One of the assumptions of this program is that it can provide a quick and effective method to benefit the homeless population at little cost to the state itself. There is no need to build new facilities, redesign current programs, or hire new staff. Rather, the only alteration would be a three-day training workshop on Motivational Interviewing, and ongoing telephone consultation when needed.

Additionally, the assumption of Motivational Housing is that it would reduce the rates at which individuals drop out of, or stop using, housing services within the state of Hawai‘i. By lowering these rates, more homeless individuals would stay off of the streets and eventually achieve a completely independent status and be more able to participate in a productive and healthy lifestyle. Prolonged periods of housing have been shown to increase the ability of an individual to achieve employment and eventually work their way off of government financial assistance (Chrystal et al., 2015).

Conceptualization of the Process of Change

The process of change within the Motivational Housing program comes from the foundations of Motivational Interviewing. Miller and Rollnick 2013 see these processes of change through several domains; four of which are essential for the individual practicing Motivational Interviewing to possess and understand if any change in the client is to be made. The four principles are: partnership, acceptance, compassion, and evocation. It is important to note that these concepts are both behavioral enactments with the client, as well as the underlying spirit of Motivational Interviewing (Miller & Rollnick, 2013).

Partnership sets the stage for an equal partners perspective that is both essential to Motivational Interviewing itself and a key component in destroying the sense of infantilization and objectification that many individuals in the homeless community experience when participating in various services. Miller and Rollnick state that “it is not something done by an expert to a passive recipient, a teacher to a pupil, a master to a disciple. In fact, it is not done ‘to’ or ‘on’ someone at all. Motivational Interviewing is done ‘for’ and ‘with’ a person. It is an active collaboration between experts” (Miller & Rollnick, 2013, p.15).

Acceptance is the second aspect that is fundamental in facilitating change in the client. This concept has its roots deep in the theoretical underpinnings of the Person Centered method of therapy developed by Carl Rogers. Fostering an atmosphere of unconditional positive regard and active listening is essential in conveying to the client that there are no power differentials here and that fostering the growth of one's own sense of autonomy and goals in life is of value (Miller & Rollnick, 2013).

Compassion is defined by Miller and Rollnick as "to actively promote the other's welfare, to give priority to the other's needs" (Miller & Rollnick, 2013, p.20). Lastly, Miller and Rollnick feel that *evocation* is crucial in order to properly foster positive and lasting change with the client. The concept of evocation also lends itself exceptionally well in the fight against instilling the feeling of infantilization. Evocation within this context is the notion that the client already has within them what is needed for change and it is the job of both the client and the professional to help bring it to the forefront (Miller & Rollnick, 2013).

Rationale for Motivating Housing

According to the available research investigating the experiences of homeless individuals and families, there are a myriad of troubling difficulties that these people face daily. Challenges varying from physical and psychological danger to infantilization and minimization of their problems from service providers. Therefore, it is imperative that an alternative solution to the traditional community outreach and housing facility-models be provided.

Motivational Interviewing, as has been discussed, emphasizes the importance of promoting self-efficacy, particularly with regard to health and behavior changes (Miller & Rollnick, 1991; Miller & Rollnick, 2002). Therapies that utilize this model, such as MET, have

demonstrated significant effectiveness for substance use-related difficulties, which is a prevalent feature of the homeless community.

In an aforementioned study conducted by Wain, Wilbourne, Harris, Pierson, Teleki, Burling, and Lovett (2010), the authors sought to investigate whether a single session of Motivational Interviewing, without feedback during the screening process, could facilitate meeting waitlist requirements, increase program entry, and support program retention in a population of homeless veterans. They were interested in whether this brief intervention would reduce the barriers to enactment that multiple sessions, lengthy assessment or assessment feedback might present when working with a transitory population or when implementing routine treatment. Following the study's completion, they noted a significant relationship between a single session, without feedback through a MI interview and increased program entry.

This is very important, as it suggests that a single, brief session of MI can be a helpful intervention for severely distressed, homeless, substance dependent veterans. Thus, creating a housing program centered upon the fundamentals of Motivational Interviewing would be largely beneficial for recipients, as well as be much better received by such individuals due to its person-centered, non-confrontational style, much unlike the infantilizing programs that currently exist.

Program Fundamentals

The Motivating Housing program is formatted much like an educational curriculum per its structure, teacher/instructor-led courses, and pre- and post-tests to enhance learning and application. Each course will be taught by two facilitators whose training requirements have been detailed in a subsequent section.

Motivating Housing begins by developing a relationship with an interested housing/shelter agency. For every ten staff members at such an agency, Motivating Housing will delegate three facilitators to instruct and provide mentorship. There will be a total of three training days within a single week, each approximately three hours long.

First, it is important to highlight that in addition to MI-specific training, the Motivating Housing workshops will be delivered within a culturally-minded framework. Motivating Housing's cultural awareness places great importance on meeting the needs of the Native Hawaiian and other rural, marginalized, and at-risk communities of Hawai‘i. Specifically, the various role-plays and didactics detailed in the following paragraphs will be tailored to Hawai‘i's diverse and complex cultural patchwork quilt. This will be accomplished via vignettes, training, and communication style.

Session 1 is a three-hour lecture series focused on enhancing behavior change and addresses MI's basic skills, the stages of change model, as well as brief interventions for housing readiness and program entry.

Prior to instruction, participants will receive a pre-test that has been adapted from Rollnick, Mason, and Butler's Health Behavior Change: A Guide for Practitioners (1999). The test asks the following questions:

> *Importance Evaluated:* On a scale from 0 to 10, how would you rank the importance of __[behavior change]__, with 0 being not important at all and 10 extremely important?
>
> *Importance Explored:* Why did you choose a __[response to previous questions]__ instead of a higher/lower number? OR What would it take to move you to a higher number?

Confidence Evaluated: On a scale from 0 to 10, how would you rank your confidence in your ability to __[behavior change]__, with 0 being not confident at all and 10 extremely confident?

Confidence Explored: Why did you choose a __[response to previous question]__ instead of a higher/lower number? OR What would it take to move you to a higher number?

Once participants have completed Session 1, they complete the same test, which ideally will illustrate higher numbers of importance, competence, and confidence.

Session 2 takes place in small groups of five participants and a single facilitator. (If an agency's staff is greater than ten, additional facilitators will attend the trainings; if the staff is less than ten, a facilitator will serve as a floater and toggle between groups.) In the groups, facilitators will first review key points from the previous lecture with the participants and then lead role-plays that employ the necessary skill sets required for Motivational Interviewing. The role-plays will address varying issues presented in a housing/shelter setting, ranging from easy to difficult.

Session 3 is another three-hour lecture that reviews MI techniques, which is assessed via a pre- and post-test (same as mentioned previously). Following the review, the facilitators emphasize the use of specific questions that establish the patient's level of readiness to change and to delineate the patient's feelings about the pros and cons of making health behavior changes and finding appropriate and sustainable housing. Finally, the participants divide into groups of five and take turns engaging in various role plays, whereby the observers generate feedback.

Following the training workshop, participants will be encouraged to seek peer supervision and consultation weekly so as to solve issues that arise, as well as to prevent

burnout. Additionally, Motivating Housing will provide ongoing telephone consultation if and when necessary for previous participants.

Membership of Motivating Housing

Due to the fact that the Motivating Housing program ideally provides training services to anyone working for a housing/shelter agency, membership is very inclusive and general. Because most shelters operate throughout the day and night, they require a staff that works around the clock. Most shelters are staffed by a director or general manager, counselors, case workers, daytime and overnight caretakers, and an administrative team that manages scheduling and booking. All staff members are welcome to participate in the Motivating Housing training program, as all members interact with the homeless population to varying degrees and would benefit from operating from a MI-style of communication and service delivery.

Role of Facilitator

The Motivating Housing program will enlist three to five appropriately trained and certified facilitators for the deliverance and supervision of those receiving the aforementioned education. The facilitators' primary duties are to assist participants/recipients throughout the Motivating Housing training via the use of evaluative and intervention delivery techniques. Said individuals must monitor the differing skill sets, personalities, and safety and ethical issues presented perpetually. The facilitators provide education/training, visual representations and modeling of specific techniques and styles of deliverance. Additionally, the facilitators offer

unwavering support and supervision for those that will ultimately deliver such services to the homeless population in varying shelters and/or housing organizations.

Due to the nature of such a program, the facilitators are expected to commute to the available housing agencies available within the state of Hawai‘i in order to provide training and supervision courses. These individuals will likely be expected to work for roughly 20 to 40 hours per week, as the program and those requesting such services, continues to develop through recognition and effectiveness.

Facilitator Training

As the Motivating Housing program focuses on the needs of the homeless population within the state of Hawai‘i, ample training is necessary for the facilitators to be appropriately versed in Motivational Interviewing techniques and styles, as well as with culturally-minded practices. These important and necessary requirements will be discussed in the following sections to provide essential details.

The facilitators must be a licensed clinical psychologist, as this is necessary in order to receive the MINT training and subsequent certification. Licensed psychologists obtain a doctorate degree in clinical or counseling psychology, complete a pre-doctoral internship and post-doctoral fellowship, and pass the Examination for the Professional Practice in Psychology. Once the MINT certification process has been completed, the facilitators will be able to effectively provide the Motivating Housing program to appropriate candidates in the community. Also of importance, facilitators must be cognizant of and adhere to clinical psychology’s ethical principles and codes of conduct.

As previously mentioned, it is necessary for facilitators to be trained in culturally-minded practices while serving the Native Hawaiian and other rural, marginalized, and at-risk

populations of Hawai‘i. While cultural competence is an important focus of clinical practice in general, the Native Hawaiian community is truly unique with regard to cultural trauma and varying psychological and medical concerns plaguing its people. Therefore, proper experience with and attention to these factors is vital when working with individuals suffering from a myriad of biological, psychological, and social/societal difficulties.

Ethical Issues

Working with the homeless population presents an interesting and complicated array of potential ethical issues. Safety remains a central and prevalent concern in clinical practice and consists of many different facets. Within the homeless population, threats to safety are many, even for those serving such individuals. Specific safety, and therefore, ethical concerns include substance use, threats to physical safety, and theft or other illegal behaviors. Therefore, the facilitators and recipients of the Motivational Housing program will be advised of such dangers; appropriate safety plans will be navigated ahead of time as well.

The two facilitators must work within their scope of competence and appropriately palliate situations in which proper delegation is necessary. With regard to aforementioned safety concerns, facilitators must refrain from making personal contact with the homeless individuals themselves, as well as delineate the importance of appropriate safety strategies with the recipients of the training program. As many of the homeless individuals have a history of substance use and/or conduct-related behaviors, careful attention will be made throughout the program’s entirety in order to protect all involved.

Immediate action would be taken, should an ethical issue present itself, particularly when safety is at stake. Documentation and consultation will be utilized as necessary, as well as encouraged for the shelter/housing staff. It is very important to highlight that the participants of

the Motivating Housing program are able to discontinue participation at any time, as their enrollment is completely voluntary.

Program Assessment/Evaluation Protocol and Form

The CIPP Evaluation Model was developed by Daniel Stufflebeam and colleagues in the 1960's. It is a comprehensive framework for guiding evaluations of programs, projects, and products (Stufflebeam, 2007). CIPP stands for Context, Input, Process, and Product Evaluation and is accounted for by the following four components: What needs to be done? How should it be done? Is it being done? Did it succeed? CIPP was developed to provide an analytic and rational basis for program decision-making.

The model's complete checklist is aimed at assessing a program's efficacy and implementing its long-term sustainability. To effectively assess the Motivating Housing program, specific components from the CIPP model are included in the appendices section of this Clinical Research Project for reference and future utilization.

In addition to utilizing the CIPP model, participants of the three-day workshops will be assessed with pre- and post-tests, as was described previously. The test uses scaling questions that determine the comprehension, application, and confidence levels of each of the participants. The aforementioned questions were selected because they reflect MI's style of building a sense of importance and confidence, as well as determining barriers and then appropriately problem-solving. The test has been added to the appendices section as well.

Summary

The Motivational Housing training program is based upon the extant literature focused on Motivational Interviewing, as well as with the findings of the literature related to the problems

that are experienced by the housing programs available to the homeless community of Oʻahu, specifically with regard to infantilization and objectification. Due to the efficacy of the technique itself, as well as the myriad of situations and conditions that MI is used in, Therefore, Motivational Interviewing is the ideal intervention technique to overcome the various barriers preventing homeless individuals from seeking lasting housing.

By implementing three-day, three-hour workshops for interested housing agencies/shelters, staff are better equipped to provide services to the homeless population, as well as encourage sustainable housing options. The training workshops are culturally-minded and responsive to the needs of the communities they serve, and utilize role-plays, didactics, and vignettes for such purposes.

To assess the effectiveness of the Motivating Housing program, participants will engage in pre- and post-tests to measure knowledge, confidence, and application. Meanwhile, the program administrator(s) will conduct an overarching program evaluation via the CIPP model for program design and productivity.

DISCUSSION

Discussion of Findings

The available literature investigating the overall effectiveness of Motivational Interviewing is robust, particularly with substance use and health behaviors. With emphasis placed on the homeless community and the particular difficulties that this population experiences, Motivational Interviewing's focus on fostering self-efficacy and an internal locus of control is paramount (Torres, Frain, & Tansey, 2019; (Miller & Rollnick, 2013). Self-efficacy, as was described previously, refers to an individual's belief in his/her/their capacity to implement the behaviors necessary to accomplish a task (Bandura, 1977, 1986, 1997). The cognitive self-

evaluations utilized in this process influence assumedly all matters of human experience, including motivation and goal completion.

For the homeless community, struggles with motivation, goal attainment, and awareness of opportunity are prevalent; these challenges often limit individuals' ability to obtain necessary services and help. When considering housing, a major criticism of homeless individuals is that many housing programs communicate in terms that do not encourage and foster a sense of self-efficacy. Instead, their message is received as infantilizing and at times, even discriminative. For a homeless person, this type of interaction is not perceived well and creates a barrier between accessing services and important care. The available research argues that infantilizing treatment strongly correlates with low entry rates, poor utilization, and early dropout rates in housing/shelter facilities.

Motivational Interviewing, an evidence-based treatment and person-centered model, operates in direct contrast from aforementioned program paradigms. Through its non-confrontational and collaborative style, MI attempts to assuage a person's ambivalence in order to move from a state of indecision towards motivation and behavior change. As the traditional housing program model has been found to be largely ineffective, it might be because recipients of these services experience the providers as being confrontational per their insistent arguments about necessary change. Motivational Interviewing, by comparison, allows clients/consumers to explore their thoughts, feelings, and behaviors, so as to find their own motivation, and most important, work out an internal plan for change.

Clinical Implications

The endlessly important clinical implications of the Motivating Housing program are extensive and impact a myriad of individuals, as well as the psychological field as a whole. This

is to say that the benefits of this training program would address varying community, state, and federal needs.

Specifically, and perhaps most immediately, the homeless population would experience drastic improvements to multiple domains of functioning. As safety is top priority, having homeless individuals seek and properly engage in housing programs would largely impact their personal safety and well-being, as well as the community in which they live. Many homeless individuals report diverse safety concerns such as abuse, violence, substance use, and theft, which are prevalent problems within these communities, encampments, and street-living. Thus, with the immense help offered through the Motivating Housing program, with regard to increasing entry rates, engagement, and sustainable housing through available agencies, individuals and families would be at far less risk from aforementioned threats.

Similarly, the communities that exist within and around homeless groups experience comparable challenges with regard to safety and danger. It is common for individuals or families to avoid public parks and transportation locations, such as bus stops, where homeless individuals have established encampments. Such areas often involve people using or selling drugs or even public urination/defecation, thus it is easily comprehensible that an alternative route would be taken so as to avoid these environments completely. Therefore, in providing a training program that focuses on the far-reaching benefits of Motivational Interviewing, with an added emphasis on housing entry and engagement, the aforementioned challenges would likely improve.

Financial concerns are a salient topic area, especially when considering the strains that homelessness places on a community and government. As was described previously, the fiscal toll that Honolulu's homeless individuals have on their surroundings is astounding. According to the National Institute of Health, homeless individuals in need of medical care often use a

hospital's emergency rooms as their primary care facilities, which costs on average $2,000 (National Institute of Health, 2013). Further, the true cost of misappropriated emergency care to hospitals and taxpayers, as was discussed in an article, found that those who were chronically homeless for longer than six months and who generally avoided shelters" made a total of 18,384 ER visits (an average of thirty times a year per individual), costing approximately $37 million dollars (Wise & Phillips, 2013).

Alternatively, Motivating Housing provides an expeditious and effective method of addressing the homeless crisis at a nominal cost. This is primarily because the national and/or local government does not have to spend on developing new infrastructure or facilities or hire new staff members. Instead, Motivating Housing's three-day training workshop and follow-up telephone consultation is much more inexpensive and is based upon a model of client-centered, culturally-minded, evidence-based practice of care.

Recommendations for Future Research

Motivational Interviewing is an avidly researched and practiced model of psychotherapy, as well as an important tool to foster self-efficacy and internal motivation necessary for making lasting behavior change. While the literature investigating its effectiveness is expansive, there is little research specifically addressing the impacts of Motivational Interviewing on program entry and engagement and sustainable housing for the homeless population.

With the implementation of Motivating Housing, as a training program for housing/shelter agencies, future researchers ought to explore the immediate, as well as long-term outcomes of such a model. A post-program evaluation would be critically important primarily due to the myriad of benefits that the Motivating Housing program offers. Specifically, it is important to assess whether the entry and engagements truly increase, as well as whether

homeless individuals and families are more likely to pursue and maintain lasting housing options. Similarly, future research would benefit from exploring the possible barriers and limitations that interfere with Motivating Housing's ability to be a helpful model of care, so as to continue to develop the ideal practice for addressing a complex and evolving population.

Assessing the training methods that the facilitators undergo is an additional important facet of future research. Unsurprisingly, it is impossible to accurately estimate the degree and type of training that facilitators must experience prior to implementing this program. This is therefore a possible limitation that the Motivating Housing training program presents. Thus, as program outcomes are assessed and evaluated, improved methods of training, prior qualifications, and personal characteristics of potential facilitators can be determined.

Conclusion

In reviewing the current literature centered upon the issue of homelessness, particularly how these individuals and families perceive the care and services they have been provided, the overarching theme appears to be that of dissatisfaction. Numerous studies have determined that despite finding some comfort and gratification with such services, more often than not, recipients experience frustration and displeasure due to the language that agencies utilize when conveying a message. This message is one of ignorance or infantilization, which often causes individuals to feel lesser than and incapable of obtaining a goal. Ultimately, these interactions have contributed to low utilization and retention rates of housing and shelter facilities.

By developing and implementing a program, such as Motivating Housing, the benefits are far-reaching. Motivating Housing, based upon a culturally-minded, person-centered, and evidence-based approach to care/treatment, serves in complete contrast to the aforementioned model of communication, as it encourages self-efficacy and autonomy.

As was described previously, by implementing three-day, three-hour workshops for interested housing agencies/shelters, the staff of housing/shelter agencies are better equipped to provide services to the homeless population, as well as encourage sustainable housing options. Then, following implementation, the Motivating Housing program's effectiveness will be assessed through pre- and post-tests to evaluate knowledge, confidence, and application. Additionally, the program administrator(s) will conduct an overarching program evaluation via the CIPP model for program design and productivity.

Developing an evidence-based, structured training program meets the complex needs of a very "at-risk" population of individuals and families. Motivating Housing's theoretical foundations will provide a helpful and effective tool for treating a vulnerable group, as well as contribute to the perpetually advancing body of psychological knowledge. Despite the program's limitations, which are unsurprising given the novelty of the philosophical underpinnings for addressing homelessness, Motivating Housing serves as an important catalyst for change on an individual, communal, and political level.

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7. Outcome of Determination (to be completed by the IRB Chair only)

*If 5A and 5B are checked and at least one of 5 C-F is checked then the project **DOES** CONSTITUTE Human Subjects Research.*

*If J (b) is checked then the project **DOES** CONSTITUTE Human Subjects Research.*

*If G, H or I, K (including all subcomponents of I) or J (a) are checked then your activity is in a category that the IRB has determined **DOES NOT** represent human subject research and no further submission of Form II or III is required. However, it is recommended you document this determination by placing a copy of this completed application in your files to address any future queries about the project. This form may still be submitted for an official determination by the IRB if required by the sponsor.*

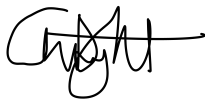
IRB Chair Certification:

Based on the information provided this proposal:

DOES ☐ *constitute Human Subjects Research and the Investigator should submit Form II or III for further review of the protocol. Research cannot start until Form II or III is approved by the IRB.*

DOES NOT ☑ *constitute Human Subjects Research and the IRB will not review it further. However, if changes to the proposed research plan occur that makes the protocol IRB-reviewable, the Investigator is required to complete a new Form I and Forms II or III as required.*

Signed,



02/04/2020

IRB Chairperson *Date*

Appendix B

CIPP Checklists

4. PROCESS EVALUATION Process evaluations monitor, document, and assess program activities. (Is it being done?)	
Evaluator Activities	Client/Stakeholder Activities—Managing and Documenting
Engage an evaluation team member to monitor, observe, maintain a photographic record of, and provide periodic progress reports on program implementation.	Use the process evaluation findings to coordinate and strengthen staff activities.
In collaboration with the program's staff, maintain a record of program events, problems, costs, and allocations.	Use the process evaluation findings to strengthen the program design.
Periodically interview beneficiaries, program leaders, and staff to obtain their assessments of the program's progress.	Use the process evaluation findings to maintain a record of the program's progress.
Maintain an up-to-date profile of the program.	Use the process evaluation findings to help maintain a record of the program's costs.
Periodically draft written reports on process evaluation findings and provide the draft reports to the client and agreed-upon stakeholders.	Use the process evaluation findings to report on the program's progress to the program's financial sponsor, policy board, community members, other developers, etc.
Present and discuss process evaluation findings in feedback workshops.	
Finalize each process evaluation report (possibly incorporated into a larger report) and associated visual aids and provide them to the client and agreed-upon stakeholders.	

5. IMPACT EVALUATION Impact evaluation assesses a program's reach to the target audience. (Did it succeed?)	
Evaluator Activities	Client/Stakeholder Activities—Controlling Who Gets Served
Engage the program's staff and consultants and/or an evaluation team member to maintain a directory of persons and groups served; make notations on their needs and record program services they received.	Use the impact evaluation findings to assure that the program is reaching intended beneficiaries.
Assess and make a judgment of the extent to which the served individuals and groups are consistent with the program's intended beneficiaries.	Use the impact evaluation findings to assess whether the program is reaching or did reach inappropriate beneficiaries.
Periodically interview area stakeholders, such as community leaders, employers, school and social programs personnel, clergy, police, judges, and homeowners, to learn their perspectives on how the program is influencing the community.	Use the impact evaluation findings to judge the extent to which the program is serving or did serve the right beneficiaries.
Include the obtained information and the evaluator's judgments in a periodically updated program profile.	Use the impact evaluation findings to judge the extent to which the program addressed or is addressing important community needs.
Determine the extent to which the program reached an appropriate group of beneficiaries.	Use the impact evaluation findings for accountability purposes regarding the program's success in reaching the intended beneficiaries.
Assess the extent to which the program inappropriately provided services to a nontargeted group.	
Draft an impact evaluation report (possibly incorporated into a larger report) and provide it to the client and agreed-upon stakeholders.	
As appropriate, discuss impact evaluation findings in feedback sessions.	
Report the impact evaluation findings to the client and agreed-upon stakeholders.	

6. EFFECTIVENESS EVALUATION Effectiveness evaluation documents and assesses the quality and significance of outcomes. (Did it succeed?)	
Evaluator Activities	Client/Stakeholder Activities—Assessing/Reporting Outcomes
Interview key stakeholders, such as community leaders, beneficiaries, program leaders and staff, and other interested parties, to determine their assessments of the program's positive and negative outcomes.	Use effectiveness evaluation findings to gauge the program's positive and negative effects on beneficiaries.
As feasible and appropriate, conduct in-depth case studies of selected beneficiaries.	As relevant, use the effectiveness evaluation findings to gauge the program's positive and negative effects on the community/pertinent environment.
Engage an evaluation team member and program staff to supply documentation needed to identify and confirm the range, depth, quality, and significance of the program's effects on beneficiaries.	Use the effectiveness evaluation findings to sort out and judge important side effects.
As appropriate, engage an evaluation team member to compile and assess information on the program's effects on the community.	Use the effectiveness evaluation findings to examine whether program plans and activities need to be changed.
Engage a goal-free evaluation to ascertain what the program actually did and to identify its full range of effects—positive and negative, intended and unintended.	Use the effectiveness evaluation findings to prepare and issue program accountability reports.
Obtain information on the nature, cost, and success of similar programs conducted elsewhere and judge the subject program's effectiveness in contrast to the identified "critical competitors."	Use the effectiveness evaluation findings to make a bottom-line assessment of the program's success.
Compile effectiveness evaluation findings in a draft report (that may be incorporated in a larger report) and present it to the client and agreed-upon stakeholders.	Use needs assessment data (from the context evaluation findings), effectiveness evaluation findings, and contrasts with similar programs elsewhere to make a bottom-line assessment of the program's significance.

□ Discuss effectiveness evaluation findings in a feedback session.	
□ Finalize the effectiveness evaluation report and present it to the client and agreed-upon stakeholders.	
□ Incorporate the effectiveness evaluation findings in an updated program profile and ultimately in the final evaluation report.	

7. SUSTAINABILITY EVALUATION Sustainability evaluation assesses the extent to which a program's contributions are institutionalized successfully and continued over time. (Did it succeed?)	
Evaluator Activities	Client/Stakeholder Activities: Continuing Successful Practices
Interview program leaders and staff to identify their judgments about what program successes should be sustained.	Use the sustainability evaluation findings to determine whether staff and beneficiaries favor program continuation.
Interview program beneficiaries to identify their judgments about what program successes should and could be sustained.	Use the sustainability findings to assess whether there is a continuing need/demand and compelling case for sustaining the program's services.
Review the evaluation's data on program effectiveness, program costs, and beneficiary needs to judge what program activities should and can be sustained.	Use the sustainability findings as warranted to set goals and plan for continuation activities.
Interview beneficiaries to identify their understanding and assessment of the program's provisions for continuation.	Use the sustainability findings as warranted to help determine how best to assign authority and responsibility for program continuation.
Obtain and examine plans, budgets, staff assignments, and other relevant information to gauge the likelihood that the program will be sustained.	As appropriate, use the sustainability findings (along with other relevant information on the program) to help plan and budget continuation activities.
Periodically revisit the program to assess the extent to which its successes are being sustained.	
Compile and report sustainability findings in the evaluation's progress and final reports.	
In a feedback session, discuss sustainability findings plus the possible need for a follow-up study to assess long-term implementation and results.	
Finalize the sustainability evaluation report and present it to the client and agreed-upon stakeholders.	

8. TRANSPORTABILITY EVALUATION Transportability evaluation assesses the extent to which a program has (or could be) successfully adapted and applied elsewhere. (This is an optional component of a CIPP evaluation. It should be applied when the client or some other authorized party desires and arranges for such a study. Sometimes such a transportability evaluation is an apt subject for a doctoral dissertation.) (Did it succeed?)	
Evaluator Activities	Client/Stakeholder Activities—Dissemination
□ Engage the program staff in identifying actual or potential adopters of the program by keeping a log of inquiries, visitors, and adaptations of the program.	□ Use the transportability evaluation findings to assess the need for disseminating information on the program.
□ If relevant, survey a representative sample of potential adopters. Ask them to (1) review a description of the program and a summary of evaluation findings; (2) judge the program's relevance to their situation; (3) judge the program's quality, significance, and replicability; and (4) report whether they are using or plan to adopt all or parts of the program.	□ Use the transportability evaluation findings to help determine audiences for information on the program.
□ Visit and assess adaptations of the program.	□ Use the transportability evaluation findings to help determine what information about the program should be disseminated.
□ Compile and report transportability evaluation findings in draft reports.	□ Use the transportability evaluation findings to gauge how well the program worked elsewhere.
□ Discuss transportability evaluation findings in a feedback session.	
□ Finalize the transportability evaluation report and associated visual aids and present them to the client and agreed-upon stakeholders.	

Appendix C

Pre- and Post-Test

Importance Evaluated: On a scale from 0 to 10, how would you rank the importance of __[behavior change]__, with 0 being not important at all and 10 extremely important?

Importance Explored: Why did you choose a __[response to previous questions]__ instead of a higher/lower number? OR What would it take to move you to a higher number?

Confidence Evaluated: On a scale from 0 to 10, how would you rank your confidence in your ability to __[behavior change]__, with 0 being not confident at all and 10 extremely confident?

Confidence Explored: Why did you choose a __[response to previous question]__ instead of a higher/lower number? OR What would it take to move you to a higher number?