
Social Work Practice with Homeless Mentally Ill People: Engaging the Client

THE HOMELESS population lives at the extreme edge of poverty. Homeless individuals have suffered severe and pervasive losses, including loss of their homes, neighborhood, social roles, family, and friends. Homeless people tend to be stigmatized and socially isolated. They have limited control over their environment, often not knowing how they will eat or where they will sleep from one day to the next. Homeless individuals often inhabit hostile environments where their personal safety is frequently threatened, both by the elements and by random acts of violence.

Estimates of the extent of mental illness in the homeless population vary, but there is growing consensus among researchers that approximately 30 percent of the homeless population is mentally ill (Hopper & Hamburg, 1984; Roth, Bean, & Johnson, 1985; Wright, 1988). The individuals described by these statistics represent the most vulnerable portion of a highly disadvantaged group. Although many were mentally disabled before becoming homeless, others may have become mentally ill as a result of the enormously stressful experience of homelessness. Life on the streets, in shelters, and in psychiatric institutions has depleted many of their internal and external resources. A feeling of helplessness in the face of powerful forces tends to pervade all of these experiences.

For the homeless mentally ill person, there is little sense of predictability in the environment or interpersonal relationships. The homeless experience and the experience of mental illness converge to erode the individual's social skills and capacity to trust. Many homeless mentally ill individuals avoid contact with others, particularly members of the mental health profession, who are often viewed as having the power to exert authoritarian control over their lives. Indeed, for this client population, contacts

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The engagement phase in practice with homeless mentally ill clients is central to work with this vulnerable population. In this article, the author develops an empowerment-oriented approach to the tasks of engagement. Specific engagement strategies include making a clear offer of service and providing voluntary services that meet clients' perceived needs. The author's thesis that homeless mentally ill individuals can be helped most effectively if their control over the helping process is maximized suggests practice strategies that encourage clients to participate fully in identifying needs, determining goals, and setting the terms of the helping process. Involving clients in program planning further promotes client self-determination and autonomy. Recent studies of programs for homeless mentally ill people suggest that empowerment-oriented approaches have been highly effective in engaging clients in the service relationship.

with professionals generally have been associated with involuntary confinement in institutional settings. Mental health services and social services are both desperately needed and greatly feared by these individuals (Plapinger, 1988). Overcoming this fear is critical to meeting the many needs of this population. *Engagement* is defined as the process of establishing mutual respect and trust in the helping relationship, which reduces fear and enables the real work to begin, and is central to all work with homeless mentally ill people.

Social workers have been in the forefront of providing services to homeless mentally ill clients, but until very recently, they have written little about this

area of practice and almost nothing regarding the engagement process. There is a growing literature that describes the population's characteristics (Arce, Tadlock, Vergare, & Shapiro, 1983; Baxter & Hopper, 1981; Morse, 1984; Rossi, Wright, Fisher, & Willis, 1987; Roth et al., 1985), their needs (Belcher, 1988; Cohen, Putnam, & Sullivan, 1984; Golden, 1986; Lipton, Sabatini, & Katz, 1983; Martin, 1982; Stoner, 1983), and the fragmentation of existing services (Bachrach, 1984, 1985; Lamb, 1984; Levine & Stockdill, 1986). The social work profession only recently has begun to address the need to develop skills for practice with homeless mentally ill clients (Berman-Rossi & Cohen, 1988; Lee, 1986; Martin & Neyowith, 1988). There is a pressing need to develop practice models that integrate traditional social work principles with innovative techniques and practice strategies for work with this client population.

In this article, the author develops an approach to the tasks of engagement in practice with this client population based on two studies of mental health programs for homeless mentally ill clients (Cohen, 1988a; Plapinger, 1988). Although homeless mentally ill people have been described as disaffiliated, hard to reach, and hard to engage (Schein, 1979), recent evidence suggests that members of this highly vulnerable population can be successfully engaged in social work services (Cohen, 1988a; Plapinger, 1988).

Social workers in five programs funded by the New York City Department of Mental Health's Community Support Systems unit have engaged hundreds of homeless mentally ill clients. While these programs share the same chronically mentally ill homeless client population, the program settings vary: a daytime drop-in center, a municipal women's shelter, a transitional women's residence, and two mobile

street outreach teams. Studies of these five programs use both qualitative and quantitative data (Cohen, 1988a; Plapinger, 1988) and make it possible to tease out the engagement strategies staff members use. These strategies suggest some of the professional tasks necessary for engaging homeless mentally ill clients and point the way to an empowerment-oriented model of practice.

Professional Tasks in Engagement

Offering Voluntary Services

Clients are far more likely to accept a service when it is clearly explained and is completely voluntary. The practice concept of a clear "offer of service" (Germain & Gitterman, 1980) is particularly helpful in engaging this client population. An offer of service must include an explicit explanation of agency services and professional functions and a clear explanation of purpose. Such a clear offer of service is particularly relevant when services are proffered to clients rather than being sought by them, as is generally the case with the homeless mentally ill population.

The voluntary nature of the offered service is critical to engaging this population. The opportunity to accept or reject services provides clients with some control over their environment—control that often has been lacking in their previous experiences with professionals. In a study of a residentially based program for homeless mentally ill women, it was found that many of the women initially avoided all contact with program staff, observing program activities from a distance until they concluded that services were not being imposed. Clients reported that they felt comfortable using program services only after they ascertained that their participation in the program was purely voluntary (Cohen, 1988a).

Offering Services that Meet Clients' Perceived Needs

Offering services that address clients' perception of their needs is a maxim for practice with all client populations

(Germain & Gitterman, 1980; Shulman, 1984). This practice takes on added significance in the engagement of homeless mentally ill individuals who characteristically avoid seeking services (Schein, 1979). Plapinger's (1988) study found that the degree of agreement between client and social worker as to service needs had a major impact on the service linkage process. For example, lack of fit between client and social worker service expectations accounted for 88 percent of the obstacles to engaging clients in substance abuse services (Plapinger, 1988).

Services associated with the traditional mental health system, such as linkage to psychiatric intervention, are not likely to appeal to homeless mentally ill clients during the initial engagement stage (Barrow, 1988; Cohen, 1988a; Plapinger, 1988). Many homeless mentally ill clients have long histories in the mental health system and have received their share of psychiatric services, many of which were perceived as harmful. Most members of this population do not perceive themselves as mentally ill or in need of mental health services (Plapinger, 1988). This client perception does not mean that psychiatric intervention is not needed or that it is not to be offered. However, in the engagement stage an offer of concrete services has been found to be far more likely to match perceived client needs (Cohen, in press; Plapinger, 1988).

Responding to clients' perceived needs most often translates as meeting their basic human needs. The only survey of self-assessed needs of homeless mentally ill individuals found concerns about housing, money, food, and physical safety to be primary, whereas concerns with medical, psychiatric, and substance abuse treatment were clearly secondary (Ball & Havassy, 1984). Engagement strategies suggested by this finding include providing food, money for transportation, clothing, shelter, and assistance with entitlements. The most salient social work concept informing engagement with homeless mentally ill clients is the time honored "starting where the client is." Future work may involve linkage to psychiatric, medical, and substance abuse services, as well as

the reparation of shattered family relationships. This work will not take place, however, until the client has been successfully engaged in the service relationship through the offer of voluntary services that meet a basic, perceived need of the individual.

The professional tasks described are illustrated by the work of an outreach team social worker with a young black man named Aaron.

Aaron had been homeless for 3 years, living on the streets of New York City. He was plagued by visions and voices of what he described as his brother Norman's spirit. Aaron engaged in many rituals, such as creating a "shield" in front of his body with the palms of his hands, rolling in dirt which he referred to as "ashes," and burning his clothing. Aaron explained that these behaviors helped to protect him from Norman's spirit invading his body. Juan, an outreach social worker from the local drop-in center, began the engagement process with Aaron on the various street corners where Aaron spent his time. In their initial contacts, Juan offered Aaron cups of coffee, small change, and casual conversation. After several weeks, Juan invited Aaron to the drop-in center where he could eat, shower, and obtain clothing. Aaron began coming to the drop-in center on a daily basis. He began participating in recreational activities with other center clients. Aaron also agreed to go with Juan to the local hospital psychiatric emergency room for medication. Aaron understood that the purpose of the medication was to stop the visions and voices that were bothering him. After being stabilized on psychotropic medication, Aaron began working with Juan on securing entitlements and obtaining housing.

Engagement can be slow and painstaking as well as highly creative. Many homeless mentally ill people are mistrustful of professionals and cautious about accepting services. It is important that the social worker move slowly when necessary, allowing the client to set the pace. Purely verbal engagement techniques may require a greater degree of relatedness than some clients are initially comfortable with. The work of a social work student who engaged an elderly and physically frail white resident of the women's shelter, diagnosed as schizophrenic, is illustrative.

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Ida had consistently eluded the efforts of the mental health team to engage her in services. She viewed the team as intrusive, suspecting that they were in league with evil forces intent on destroying her. Maureen, a young social work student, observed Ida's daily routine of feeding bread crumbs to the pigeons. Maureen began to feed the pigeons alongside her. Maureen initially did not attempt to interact with Ida. After several weeks, she began to offer Ida some of her bread crumbs when Ida's supply ran out. Over a period of several months, Maureen and Ida began to talk, first about the pigeons, then about Maureen, and finally about Ida. Eventually, Ida agreed to let Maureen help her apply for supplemental security income, in part because she wanted to be able to afford more bread for "her" pigeons. Subsequently, she agreed to have Maureen accompany her to the medical clinic. Very gradually, a strong helping relationship was forged. (Cohen, in press)

Building Connections

In communal settings such as shelters and residences, groups have been used to engage clients as members of a community (Berman-Rossi & Cohen, 1988; Martin & Neyowith, 1988). A high degree of shared needs and the potential for mutual aid have been found to be particularly strong among people who live together (Forman, 1971). The isolation and limited social skills of homeless mentally ill individuals cannot be fully addressed through individual services alone. The experience of mutual aid within groups has been found to be particularly helpful to this client population (Berman-Rossi & Cohen, 1988; Breton, 1988; Martin & Neyowith, 1988).

Just as engaging clients in individual services requires a clear offer of voluntary services that meet client's perceived needs, engaging clients in group experiences requires a similar approach. At the transitional women's residence, a group activities program enabled the development of strong social relationships among clients (Cohen, 1988a). In this setting, social workers engaged homeless mentally ill clients in group activities by inviting them to participate in selecting and planning groups. Clients were initially suspicious because they had never before been asked to participate in program planning. However, the

social workers continued to request assistance in choosing and designing groups and made program funds available to clients to spend on group activities. A program of activities was developed that met clients' needs and fostered mutual aid and a spirit of community among the women (Cohen, 1988a). Two groups that were particularly successful in engaging clients were the Tenants Meeting and the Dinner Group.

The Tenants Meeting, an outgrowth of a discussion between clients and program staff, focused on problems within the residence and the importance of clients' rights as tenants. Meetings were held on a bimonthly basis at the suggestion of clients and were cochaired by a client and a social worker. These meetings were a forum in which clients could raise and begin to resolve such matters of community concern as fighting, sharing bathrooms, unsanitary conditions, and inadequate heat. These meetings underscored the shared nature of clients' concerns, fostered an atmosphere of mutual support, and decreased social isolation among the women (Cohen, 1988b).

The Dinner Group sought to engage clients by providing an opportunity for mutual aid and skill-building while meeting the need, articulated by many of the women, for a meal they could choose and prepare themselves (Berman-Rossi & Cohen, 1988). Group members shared responsibilities for planning menus, shopping, cooking, eating together, and cleaning up. Although the social work staff viewed the group as a vehicle for generating mutual aid, fostering a sense of community, and building interpersonal and daily living skills, what engaged clients was the opportunity to eat a meal they had planned and prepared themselves.

The concept of client self-determination is critical to this approach to engaging clients in group activities. Not only were group services not imposed on clients, clients actually helped to develop and design many facets of the activity program. Homeless mentally ill people are among the most powerless groups in society—they have been "done to" and "done for" for many years. Engaging members of this popu-

lation in services requires that professionals demonstrate their willingness to "do with" clients.

Empowerment

The concept of empowerment underlies the engagement approach. In this context, empowerment refers to the critical human need of being an effective and creative participant in one's environment (Freire, 1970; Rose & Black, 1985). Empowerment-based social work practice has been defined as having the goal of helping clients from disempowered groups move toward an orientation of internal locus of control and external locus of responsibility (Hegar & Hunzeker, 1988). Such an orientation characterizes individuals who "believe in their ability to shape events in their own lives, if given the chance" (Sue, 1981, p. 87).

As long as homeless mentally ill individuals are viewed and treated as helpless, their sense of powerlessness over their lives is reinforced. Because the homeless experience and the experience of mental illness tend to rob people of control over their lives, engagement and rehabilitation must take place within the context of practice that seeks to restore the client's ability to participate effectively. This practice requires an appreciation of client strengths and an approach that builds on client competence.

The engagement strategies discussed flow from an empowerment orientation to practice. Mutuality and the building of trust in the service relationship is key. Mutuality implies a partnership between the social worker and the client in which decisions are made through consensus, rather than coercion. Such a partnership has strong potential for empowerment because it reduces the power discrepancy inherent in helping relationships (Germain & Gitterman, 1980). Empowerment-based practice is based on clients and social workers collaborating as peers to solve problems (Solomon, 1985). A sense of partnership is communicated in engagement when services offered are clearly explained, voluntary, and available to meet the needs identified by clients. Involving clients in choosing and designing

services further communicates the view that clients are competent and capable of making decisions that affect themselves and the world around them.

Implications

In this article, the author has attempted to articulate an approach to engage homeless mentally ill individuals in the helping process. Specific engagement strategies include making a clear offer of service, providing services in a voluntary and flexible manner, gearing services to meet clients' perceived needs, and building connections between clients through mutual aid groups. Undergirding these strategies is the goal of client empowerment. The belief that homeless mentally ill individuals can be helped most effectively if their control over their environment is maximized leads to an approach in which clients are encouraged to participate fully in identifying needs, determining goals, and setting the terms of the helping process. Involving clients in program design and development further promotes client self-determination and autonomy. The experience of social workers in programs for this client population suggests that this approach is both feasible and effective. Clients are more readily engaged in services that they have a role in developing. An active role in the service process and involvement in service planning can provide clients with the experience of shaping events in their own lives.

The empowerment-oriented approach to engagement that has been delineated is likely to be applicable to other disadvantaged client populations. Homeless mentally ill people are not alone in their need to participate effectively and creatively in the helping process and in the world around them. Thus, building practice models for work with homeless mentally ill people is likely to benefit other vulnerable client groups.

Social workers who serve the homeless mentally ill population are likely to encounter many obstacles to effective practice. The severe shortage of services and resources geared to the needs of homeless mentally ill people cannot be overcome by practice models alone. There is a pressing need for practi-

tioners, program planners, and policymakers to become more aware of the needs of this client population and to learn more effective methods for delivering services. Engaging homeless mentally ill clients is only a beginning as clients must be engaged in a service delivery system that is organized to meet their needs. If practitioners become more skilled at engaging clients, however, services and resources should become more accessible to one of the most disadvantaged and underserved groups in our society.

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