The intervention and assistance to the chronically mentally ill who are experiencing homelessness

James Allen Milner Sr
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THE INTERVENTION AND ASSISTANCE TO THE CHRONICALLY MENTALLY ILL WHO ARE EXPERIENCING HOMELESSNESS

By

James Allen Milner, Sr.
Master of Divinity, Interdenominational Theological Center, 1985

A Doctoral Dissertation
submitted to faculties of the schools of the
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ABSTRACT

THE INTERVENTION AND ASSISTANCE TO THE CHRONICALLY MENTALLY ILL WHO ARE EXPERIENCING HOMELESSNESS

by
James Allen Milner, Sr.
May 2006
115 pages

The writing of this dissertation was an effort to address the issue of providing assistance to those persons who have been diagnosed with a chronic mental illness and were also experiencing homelessness. The author addresses several questions surrounding this issue. Ultimately, it was the desire of this writer to develop a Safe Haven program for this population that would create a residential service center. At this writing, there is not such a program in the State of Georgia.

Among the many questions surrounding this issue that this writer addressed was:

What is the history behind this problem? How did so many people in this targeted population become homeless? Is there a possible solution? What does the bible have to say regarding this issue and what if anything can the Faith community do to intervene and render assistance to this population? The questions were challenging.

The intent of this dissertation was to provide some answers and design a program that could be replicated by any congregation that believed they were called to such a mission.
The project consisted of ten men who were homeless and had a diagnosis of a chronic mental illness. The period of time these men were observed was a minimum of six months. The staff consisted of a director of counseling who is a licensed master of social work degree holder who specialized in psychotherapy; there were case managers; peer specialist; residential support staff; night managers and a dietician.

The program was designed to include volunteerism from the members of the sponsoring congregation. Funding was sought through the support of the sponsoring church as well as other churches and individuals. The bulk of the funding however was provided by government sources.

The overall hypothesis was that if given adequate support and assistance, those persons targeted by this effort could become stabilized, non-symptomatic and able to live in permanent housing with the necessary supportive services.
DEDICATION

I dedicate this dissertation to my mother, Mildred, who was determined to see me get an education by any means necessary. To my wife Janice, who for the past forty years has believed in me, forgiven me and encouraged me. I thank God for both these women who love and believe in me.

I also dedicate this dissertation to my three children, Sherri Denise, James Alan II, and Tiffani Dionne. They have always been the wind beneath my wings, my reason for living and my greatest contribution to the world. I thank God for each of them.

Finally, I dedicate this dissertation to the memory of my Great grandfather, John Allen Worthy, who taught me to be a man and my maternal grandmother, Zella Gaither-Clowers, who taught me to love God and Dr. Joseph E. Lowery who taught me to stand up for justice and righteousness for all people.

May This Work please and glorify God.

J. A. M.
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I am deeply grateful to the many persons who have made contributions to the success of this effort; I will be forever indebted to each of you.

To Mrs. Carolyn Morgan my Administrative Assistant for typing and interpreting my challenging handwriting.

To all the members of the Chapel of Christian Love Missionary Baptist Church, for all your support and especially the Associate Pastors who took on much of the Pastoral duties and allowed me time and space to write and work with this project.

To the members of the staff at Odyssey III who made such major contributions in helping me compile the data for this project. Thank you, Michelle, Verhonda, and James II.

This work would probably not have been completed without the prayers, understanding, and support of Dr. Stephen C. Rasor and Dr. H. Wayne Merritt, Thank you for caring. Further thanks goes to Dr. Carolyn McCrary and Reverend Terry Walker, Sr., members of my committee. Last but certainly not least, to Mrs. Cecelia Dixon, thank you for your tolerance, kindness and encouragement.
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INTRODUCTION

It is estimated that more than ten thousand people will experience homelessness in the metropolitan area of Atlanta, Georgia at some point and time this year. Of the number of persons experiencing homelessness, more than thirty percent are believed to be chronically mentally ill by mental health providers.

The ministry issue addressed in this dissertation project was the intervention and assistance to the chronically mentally ill who experienced homelessness. It was the desire of this writer to demonstrate that a church, regardless of its size, can make a difference in the lives of the persons who need assistance and intervention in this instance. A church does not have to be a mega-church to do mega-ministry. The project details ways in which the church can move from advocacy to action in providing the assistance needed by this targeted group through nurture, staffing, funding and spiritual recovery.

This issue is of great importance because our larger social communities have either abdicated their responsibilities to the population of people who are homeless and mentally challenged, or, they, as yet, have failed to recognize this population as a focus of ministry and service. We, at The Chapel of Christian Love Baptist Church, believe that if the larger community would address the needs of those who are chronically mentally ill and experiencing homelessness the problem of long-term homelessness could
be reduced by more than fifty percent. We are concerned as we look at the history of how municipalities and governments have simply renounced their obligation to provide care for persons, citizens, who suffer from homelessness and chronic mental illness. The broader community has been conspicuously quiet on the subject and the church has not taken a position on ministry to this population.

Moreover, The Chapel of Christian Love Baptist Church has a keen interest in responding to the needs of this population because of our perceived calling of the church to respond to the needs of the least and marginalized of our society. We believe the call of Jesus to the seventy who were sent out to minister is the call of the church today.

Among the instructions given to the seventy was the directive to "heal the sick."¹

In the church's effort to do ministry in this area, motivation and support from the works of James W. Fowler, in his monographs, *Faith Development and Pastoral Care*, and *Stages of Faith: The Psychology of Human Development and the Quest for Meaning*, and E. Fuller Torrey, *Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill* are of informative significance. Fowler addresses the issue of Pastoral Care as the faith communities' Practical Theology that is called upon to integrate an ecology of care and an ecology of vocation,² and Torrey documents the history of the deinstitutionalization of mentally ill patients in America's hospitals.

When Fowler refers to an ecology of care, he states:

"We will try to honor the richness of relationships in the interdependent community of the congregation. Some of the interdependence of the congregation can be seen in the formal activities of a church: public worship, the governing boards, the men's and women's group, Sunday-school classes, work areas, committees, youth groups, and the like. Much

¹Luke 10:9 NIV.

of the “Thickness” or the redemptive toughness of congregations as ecologies of care, however, is not visible on organizational charts, in membership lists, or in the more or less formalized activities of the community.\(^3\)

He goes further to refer to relationships such as friendships, families with long histories in a congregation, small groups such as prayer groups or support groups, and those who interact frequently on the telephone, and how they respond spontaneously when emergencies arises. These and many other uniquely intimate interactions and reliances constitute important elements of a strong congregational life. Fowler states: “These, in addition to the more visible and formalized structures of church activity, constitute an ecology of care."\(^4\)

Further, when Fowler speaks of the ecology of vocation, he says it has to do with the responses persons make to “God’s call to partnership and with the way that those responses exerts ordering power in a person or communities’ priorities and investments of self, time, and resources.”\(^5\) He concludes; “Pastoral Care consists of all the ways a community of faith, under pastoral leadership, intentionally sponsors the awakening, shaping, rectifying, healing, and ongoing growth in vocation of Christian persons and community under the pressure and power of the in-breaking kingdom of God.”\(^6\)

Relatedly, E. Fuller Torrey in No Where to Go: The Tragic Odyssey of the Homeless Mentally Ill states:

The professionals promised to improve the lot of the seriously mentally ill, abused and neglected in the nation’s asylums. Deinstitutionalization it would be called, officially defined by the Director of the National Institute

\(^3\) Ibid., 20.

\(^4\) Ibid.

\(^5\) Ibid., 32.

\(^6\) Ibid., 21.
of Mental Health as 1) the prevention of inappropriate mental hospital admissions through the provision of community alternatives for treatment, 2) the release to the community of all institutionalized patients who have been given adequate preparation for such a change, and 3) the establishment and maintenance of community support systems for non-institutionalized people receiving mental health services in the community.

So what happened (he asked)? Certainly nothing remotely resembling the definition of deinstitutionalization given above. Instead, the seriously mentally ill were dumped out of mental hospitals into communities with few facilities and little aftercare. And as soon as they were gone, the hospitals were closed down so that they could not return. Rather than deinstitutionalization, which implied that alternative community facilities would be provided, what took place was simply depopulation of the state hospitals. It was as if a policy of resettlement had been agreed upon but only eviction took place.7

The following chapters illustrate the journey of the ministry staff and the congregation of the Chapel of Christian Love Baptist Church as we have sought to address the ministry issue of homelessness and mental illness. Chapter One describes the ministry setting, provides geographic and demographic information concerning the ministry setting in the larger metropolitan Atlanta, Georgia area and the local church community, as well.

In Chapter Two, a review of articles relating to homelessness and mental illness is discussed in connection with theological writings that provide the basis for this writing project and the theoretical foundation by which we at the Chapel of Christian Love Baptist Church addressed this ministry issue. Along with the biblical literature, James W. Fowler and E. Fuller Torrey are especially significant.

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In Chapter Three, the ministry program is discussed. Here we describe the location of the ministry, its staffing, budgeting and operation along with case studies and evaluations of ten adult men who were a part of the program.

A summary and conclusion, Chapter Four, presents the findings of this ministry addressed to homeless men who are mentally challenged. Here is indicated what we have learned through the project as well as what might have been done differently. We make suggestions as to how this project may be adapted or modified in other church settings. It is our desire that others may take these findings and improve upon them so that homeless and mentally challenged persons may have a richer, fuller life in the future and that we who follow Christ and live in civil society may learn the meaning of discipleship and faith.

The writer believes his efforts to lead his congregation to respond to the needs of the community over the past thirty years has resulted in a commitment to serve as directed by God. Under his pastoral leadership the congregation began responding to the need to address hunger within the community. He established a food pantry to help supplement the resources of the poor, unemployed, elderly, and the underemployed.

Similarly, the author was asked if he would provide food for an emergency shelter serving women and children. He committed to addressing this need two nights a week. He was later asked if he would provide three hundred sandwiches once a month for an emergency shelter serving an average of one hundred fifty men nightly during the winter months. Once again, he led his congregation to respond to this request.
While accepting the opportunities to do ministry, the writer began to emphasize
the biblical mandate to render such services. He became intentional about finding
biblical narratives that support the investment of time and resources to this cause.

This teaching effort resulted in an expansion of that service to include service to
the homeless population living on the streets without benefit of shelters. The writer
began recruiting the elderly and retired women of the church to cook food to be served in
the evenings on the streets of the city where the homeless persons gathered. It was
decided that an evening meal served from the church’s van would be most appropriate for
two reasons. First, it would provide meals for the many homeless persons who work as
temporary day laborers. (They are usually relegated to the most hazardous work for the
minimal amounts of monies.) Secondly, evening meals would give the church members,
who are employed, time to finish their day’s work for their employers and then volunteer
in the homeless ministry at church.

It is this group that would carry the prepared meals into the downtown area and
serve them. The number of meals provided each day to this group of persons was
approximately two hundred.

This ministry was practiced for over five years and this shaped the ministry of the
church to place high priority on serving the urban poor and homeless. This ministry has
afforded the church the opportunity for out-reach and evangelism. The poor and
homeless have been the primary target of its ministry efforts.

Subsequently, the congregation has experienced on-going growth in its spiritual
walk with God. The community recognizes and supports the efforts of this church.
Some twelve to fifteen churches support and collaborate in this ministry and together they are rectifying and healing this deplorable condition of homelessness and hunger.

As a result of the influence from the works of Dr. Fowler, this author is more certain that he has a call to lead the congregation of the Chapel of Christian Love to undertake the task of intervening on behalf of the chronically mentally ill persons who are experiencing homelessness due in no small part to their mental illness. The intentionality of this effort will be seen in how this congregation exerts effort, expands its resources and displays the passion for the work undertaken.

In the following chapters the writer will address this ministry issue as follows:

Chapter one on ministry context will afford the writer the opportunity to describe the ministry setting where he will give a vivid description of the geographic and demographic specifics of the setting. This will allow the writer to further clarify the ministry issue and why he has chosen to address it. The writer will then summarize the ministry context by including some of the historical flavor of the culture of the setting.

In chapter two, the writer will seek to address the empirical literature. He will begin by looking at some of the literature that captures the activity surrounding the issue of mental health from several decades ago. The author will examine the effects upon the service provider network for the mentally ill. The writer will review recent articles that have been produced by various researchers in the field to ascertain their findings on the issue. The author also examined the Theological Literature that addresses the issue. The writer demonstrates how Biblical Literature speaks to and compels the church to address the issue. Finally, the author sought to summarize, and synthesize the information gathered in this chapter and relate it to practical applications in this ministry setting.
In chapter three, the writer reviewed the ministry project. The first objective was to describe and design the program. That included a discussion on the issue of location. We sought to locate an adequate facility and determine staffing needs. The process of establishing the budget and identifying possible support funds was addressed in this chapter. Personal participants in the project include members of the local church; there is also a need for a nurse, a dietitian, Bible Study teachers and others who may be found among the congregation members that can provide some of these services. Beyond the church, the writer sought out a servicing psychiatrist; a psychiatric nurse; social workers; a clinician to run group therapy; payees to handle clients’ money; case managers and a population of ten adult males who are diagnosed with a chronic and disabling mental illness currently experiencing homelessness. Some of these men were dually diagnosed as substance abusers and, therefore, the writer identified other professionals to help the clients address this issue. In this chapter the author indicated specifically what was done in the project, shared the evaluation and reported the final results and gave a summary.

In chapter four, the author will examine the results of his efforts to determine what was accomplished. The writer also determined what was learned through the project, as well as what might have been done differently and how this project may be adapted or modified as a ministry in other church settings. The church from whence this ministry was conceived and implemented is the Chapel of Christian Love Baptist Church, Atlanta, Georgia.
CHAPTER I
MINISTRY CONTEXT

Introduction

This chapter describes the ministry setting of the Chapel of Christian Love Baptist Church. It describes the geographical boundaries, including the immediate neighborhood surrounding the church, the larger parish area, and the theological stance of the church, organizational structure, interpersonal relations, demographics, and historical events that impact the church's present situation.

The setting for ministry at The Chapel of Christian Love Baptist Church is rather broad, in that, it encompasses the church, the outreach center, and the city as a whole. The larger parish area is metropolitan Atlanta, Georgia. "Atlanta" is composed of seven to eight counties with approximately one and a half to two million people. People who are homeless tend to gravitate to the downtown Atlanta area, primarily because there are more services and facilities for persons experiencing homelessness located in this area.

The most inclusive aspect of the larger parish area is Fulton and Dekalb counties and the city of Atlanta, itself. Most of the targeted ministry population is found in these particular areas. This broader area includes the entertainment district, the hotel and restaurant districts and neighborhoods that are so diverse that the residents hardly ever see one another. It is an example of a city of the very well-to-do, or, upper class, and a
large underclass. While there is the perception that the population of African Americans grossly out-numbers any other group in the city, the reality is that the city has lost much of its former population due to the high cost of living and the elimination of much of the subsidized housing for the poor.

To fully understand the politics of this city, requires one to acquaint themselves with the “quality of life” ordinances that seek to control the movements and behavior of the poor and homeless in the city. These ordinances are designed to insure a better quality of life for the gainfully employed and tax paying citizens. The recently passed anti-panhandling ordinance provides a testament to the attitudinal constraints toward the poor in the larger parish of the ministry setting. The irony (here) is that the city of Atlanta is often thought of as the “Black Mecca,” or, some oasis of hope for African Americans. This broader setting has been a place where economic advancement and pseudo-racial harmony exists. The reality is, however, that we can find enough good will and philanthropic willingness to generate hundreds of millions of dollars to house exotic fish, but have not seen the willingness nor the benevolence to provide the same level of dollars for housing the poor and homeless of the city.

While there is a lot to be desired from the city council and others when it comes to compassion for the poor, the current Mayor, Shirley Franklin, demonstrates a determination to make a difference in the lives of the citizens of her city who are experiencing homelessness. When Mayor Franklin began her first term as mayor, she invited the Faith Communities to meet with her on a monthly basis. She did not limit this invitation to the religious leaders serving in the city proper. She extended the invitation to persons in ministry regardless of the city or (metropolitan) county in which they
served. This was an interfaith group and they were encouraged to advise the mayor on the issues they saw as priorities for her administration to address. The initial interfaith group numbered from forty-five to sixty individuals; most were leaders of a church, mosque or synagogue.

The interfaith group identified three issues they thought the mayor should make top priority. The first priority was the issue of homelessness. The consensus of the interfaith group was that there were too many homeless people and among this population it was noted that the fastest growing group consisted of women and children. The second issue addressed was adequate and affordable (low income) housing, and third was the issue of public safety.

The mayor formed task forces or sub-committees for each issue. They discovered that these three issues were interconnected and realized they should devote all their efforts to addressing homelessness. As a result, housing would inevitably be a part of the conversation as well as the issue of public safety. The interfaith task force developed the idea of a commission on homelessness. The commission was charged with identifying the immediate things the mayor could do to address the problem and plan toward ending chronic homelessness within ten years. The commission also concluded that the mayor could do very little without the cooperation of surrounding cities and counties participating. The mayor accepted these findings and initiated a plan to enlist the cooperation and participation of the other governments in the region.

The mayor did contact the governmental leaders and, eventually got the state and six metropolitan counties to commit to working with what would become a regional commission on homelessness. The pastor of the Chapel of Christian Love Baptist Church
involved himself from the inception of the first interfaith group and at present serves as convener for the Mayor's Faith-Based Round Table and on the Regional Commission on Homelessness, as well. The commission has raised some twenty-six million dollars from the private sector to address the problem of homelessness to date. There have been many positive changes in the effort to provide services to those experiencing homelessness. Over four hundred additional bed spaces have been created for the homeless population in Atlanta and a new service center has been developed. Anyone not having a place to stay for the night can find refuge in this center.

The service center also offers assessments and referrals to service providers for the homeless population. Some providers have staff members stationed at the service center. The center is open twenty-four hours a day. The mayor has identified a way to further generate some twenty million dollars from existing tax revenues to be used to develop permanent housing with supportive services. The city council has given its support to this effort as well. Many of the governments represented on the commission are developing services in their geographic areas. Many homeless people have been reconnected with their families in other cities and provided with transportation to reunite with these families. Hopefully, other regional leaders in government, interfaith groups, and philanthropic groups, business groups and the federal government will notice the results of Mayor Franklin and the Commission on Homelessness and duplicate its efforts nationwide.

The immediate neighborhood surrounding the Chapel of Christian Love Baptist Church is unique. To the east of the church are people who fall into the lower middle-income level and others who live at or below the poverty level. To the west of the church
are older black people who have experienced upper middle-class status and middle-age, as well as, young adults living in the top twenty percentile of income earnings for the city.

Houses in this area range from older homes that once sold from twenty to one hundred thousand dollars, but now sell for well over one hundred thousand. The new developments to our west are selling from the high two hundred thousand to over a million dollars. Because of escalating property taxes, the poorer persons to the east and the older persons to the west are being forced to move out of the community.

Gentrification is on the rise throughout the city of Atlanta.

The demographics of our immediate community is approximately 61.4 % African American, 33.2% white and 5% percent Hispanic or Latino with a growing presence of white and Hispanic population. There are more young adults with children populating the area and more professionals than ten or fifteen years previously.

At the outset of this ministry, the exact number of persons experiencing homelessness was unknown but believed to be anywhere between ten and twenty thousand annually. Over the past fifteen years, there has been more response to this growing problem by all levels of government. The private sector has increased its efforts to address this issue through the development of non-profit organizations and faith-based efforts. As a result, the most recent census taken of the population in the Atlanta, Fulton, and Dekalb counties (which make up the immediate metro area), found a total of six thousand eight hundred and thirty-two (6,832) persons who were homeless at that particular point in time. Of that number, the vast majorities were single individuals (5,673) or 83%. Of this number, four thousand five hundred sixty-eight were adult (4,568)
males; nine hundred sixty-six (966) were adult females; one hundred seven (107) were male adolescents, and thirty-two (32) were female adolescents. There were one thousand one hundred fifty-nine (1,159) persons in family settings. Of these families, forty-four percent (44%) were headed by females and eleven percent (11%) were two parent families. Of the family members (1,159) seven hundred seventy (770) or 66% were children.\textsuperscript{1}

In describing the immediate neighborhood, one must include the downtown property purchased by the church for out-reach ministry in the year of 1988. The church was providing prepared meals for those who were hungry and homeless, or, simply, to those who expressed a need. It soon became apparent that the greater need for such service was in the downtown Atlanta area. While the church tried to bring the recipients to the church for services, the number of people needing a meal was simply too great for this approach to be successful.

In response, the church prayed for and looked for a downtown location where this ministry could be conducted. After about a year of searching and praying, the church found a building centrally located at 276 Decatur Street in downtown Atlanta and purchased the building as a ministry location.

The location was ideal because it is in walking distance of public transportation, the County Hospital, Georgia State University, the Public Library, the Convention Center; baseball, basketball, and football stadiums, and the hotel district. These locations usually provide many services and, importantly, temporary employment. There were two public housing communities nearby, however, they have been closed and the tenants were

displaced. In addition, there are many homeless service centers within walking distances of this new ministry location that collaborate with the out-reach ministries of various churches in the area.

Of these ministry centers, there are a significant number of Protestant denominations, a Roman Catholic Church, the Shrine of the Black Madonna, and a New Thought Church involved as well. There are also Christian, Muslims and neo-Christian congregations in our immediate vicinity. These churches, mosques, and synagogues have diverse leadership with both black and white and male and female pastors. When the invitation to Christian discipleship is extended in worship at the Chapel of Christian Love, it is stressed that the offer is for Christian discipleship and not simply church membership. The persons served are offered membership in the nearby Church of God, larger Baptist Churches, the Episcopal Church, the New Thought Church, the United Methodist Church, the Lutheran Church and membership in our congregation.

THEOLOGICAL STANCE

The Chapel of Christian Love Baptist Church is a mid-size Baptist church with an approximate number of six hundred active members, which includes women, men, and children. Founded in 1976, the emphasis then and now continues to be the seeking of the “un-churched” among the impoverished. This impoverished group was initially favored out of the conviction that the impoverished have a special place with God.

David J. Bosch in a similar way confirms this writer’s position, when he quotes Mazamisa:

Luke’s concern is with social issues the author writes about: with the demons and evil forces in first century society which deprived women,
men, and children of dignity and selfhood, of sight and voice and bread
and sought to control their lives for private gain....

Today, this church has attracted the poor, the middle class, and to a varying extent
the upper middle class. As a congregation we embrace the mission of Christian service
found in Matthew 25:31-46.

When the son of Man comes in his glory, and all the angels with him, he
will sit on his throne in heavenly glory. All the nations will be gathered
before him, and he will separate the people one from another as a shepherd
separates the sheep from the goats. He will put the sheep on his right and
the goats on his left. Then the King will say to those on his right, ‘Come,
you who are blessed by my Father; take your inheritance, the kingdom
prepared for you since the creation of the world. For I was hungry and
you gave me something to eat, I was thirsty and you gave me something to
drink, I was a stranger and you invited me in, I needed clothes and you
clothed me, I was sick and you looked after me, I was in prison and you
came to visit me.’ Then the righteous will answer him, Lord, when did we
see you hungry and feed you, or thirsty and give you something to drink?
When did we see you a stranger and invite you in, or needing clothes and
clothe you? When did we see you sick or in prison and go to visit you?
The King will reply, ‘I tell you the truth, whatever you did for one of the
least of these brothers of mine, you did for me.’ Then he will say to those
on his left, ‘Depart from me, you who are cursed, into the eternal fire
prepared for the devil and his angels. For I was hungry and you gave me
nothing to eat, I was thirsty and you gave me nothing to drink, I was a
stranger and you did not invite me in, I needed clothes and you did not
clothe me, I was sick and in prison and you did not look after me.’ They
also will answer, ‘Lord, when did we see you hungry or thirsty or a
stranger or needing clothes or sick or in prison, and did not help you?’ He
will reply, ‘I tell you the truth, whatever you did not do for one of the least
of these, you did not do for me.’ Then they will go away to eternal
punishment, but the righteous to eternal life. (Matthew 25:31-46 NIV).

This Matthean text (25:31-46) forms the basis for our theological stance. While
the theology of the Church embraces “one Lord, one faith, one baptism,”3 we are clear
that this one Lord is the Father, Son, and the Holy Spirit. We believe and adopt the
understanding of faith stated in the Hebrews 11:1-11.

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2Found in David J. Bosch, Transforming Mission: Paradigm Shifts on Theology of Mission
3Luke. 4:4-5 NIV.
In Hebrews we read,

Now faith is being sure of what we hope for and certain of what we do not see. This is what the ancients were commended for. By faith we understand that the universe was formed at God’s command, so that what is seen was not made out of what was visible. By faith Abel offered God a better sacrifice than Cain did. By faith he was commended as a righteous man, when God spoke well of his offerings. And by faith he still speaks, even though he is dead. By faith Enoch was taken from this life, so that he did not experience death; he could not be found, because God had taken him away. For before he was taken, he was commended as one who pleased God. And without faith it is impossible to please God, because anyone who comes to him must believe that he exists and that he rewards those who earnestly seek him. By faith Noah, when warned about things not yet seen, in holy fear built an ark to save his family. By his faith he condemned the world and became heir of the righteousness that comes by faith. By faith Abraham, when called to go to a place he would later receive as his inheritance, obeyed and went, even though he did not know where he was going. By faith he made his home in the Promised Land like a stranger in a foreign country; he lived in tents, as did Isaac and Jacob, who were heirs with him of the same promise. For he was looking forward to the city with foundations, whose architect and builder is God. By faith Abraham, even though he was past age—and Sarah herself was barren—was enabled to become a father because he considered him faithful who had made the promise. (Hebrews 11:1-11 NIV).

Our theology further dictates that we are the community sent out to be the “salt of the earth” and the “light of the world,” as indicated by Jesus in Matthew 5:13-16.

You are the salt of the earth. But if the salt loses its saltiness, how can it be made salty again? It is no longer good for anything, except to be thrown out and trampled by men. You are the light of the world. A city on a hill cannot be hidden. Neither do people light a lamp and put it under a bowl. Instead they put it on its stand, and it gives light to everyone in the house. In the same way, let your light shine before men, that they may see your good deeds and praise your Father in heaven. (Matthew 5:13-16 NIV).

The Chapel of Christian Love Baptist Church believes that in The Sermon On The Mount, Jesus spells out the theology for the church universal. Jesus calls his followers to be the manifestation of the Lord our God impacting the suffering of humankind.
We also believe in the theology of the priesthood of all believers as described in 1st Peter 2: 9-10 and are, therefore, called to be priests to each other.

But you are a chosen people, a royal priesthood, a holy nation, a people belonging to God, that you may declare the praises of him who called you out of darkness into his wonderful light. (1st Peter 2:9-10 NIV).

At the Chapel of Christian Love Baptist Church we seek to find many and diverse ways to actualize our priesthood to one another and the world at large.

The organizational structure of The Chapel of Christian Love Baptist Church is not unlike other typical Baptist churches. There is an administrative board consisting of nine members, a board of trustees consisting of five members, and a deacon’s board whose ministry is less focused administratively and more spiritually. Further there is a congregation of approximately 600 active members. The pastor serves at the pleasure of the congregation. The power is entrusted to those in the pews, that is, the congregation as a whole. Each member has a single vote.

While, as Baptists, our mode of baptism is immersion, and we boast of having no hierarchy there is a larger ecclesiastical structure in which we participate. We, as a congregation, belong to the Mount Calvary Missionary and Education Association, which is one of many associations that make up the fifth district of the General Missionary Baptist Convention of Georgia. Being a member of these organizations aligns us with the National Baptist Convention U.S.A., Inc.

**INTERPERSONAL RELATIONS FROM WHICH WE FORMED THE MINISTRIES**

Good interpersonal relationships exist between members of the congregation and the leadership staff. The founding pastor of the church has had the privilege of
fashioning the program design and training others in leadership positions. The church has witnessed the miracles of God as God has given them the vision for the church. God has allowed the church to achieve what might have been considered impossible. This impossibility speaks not only of the acquisition of buildings and land, but, to the healing power of prayer over sickness and terminal illnesses.

There is a unique relationship among those involved in the out-reach ministry to the homeless. When the church started this ministry, the members would prepare food for the homeless and would take this food and serve it to the homeless persons on the streets. This action strengthened the bond between members of the out-reach ministry and Pastor and those to whom they were extending ministry.

After purchasing a building in which to conduct this ministry, the members once again rose to the occasion and performed all the demolition work needed before renovations could begin. These same members, along with members of the National Association of the Remodeling Industry, volunteered to do the work of renovation. The actual cost of the work and materials donated would have exceeded two hundred fifty thousand dollars. Given the labor and the generosity of those involved, the amount of monies spent on this project was considerably less. In addition, because of the relationship between members of the church and members of the broader community, the city and the state provided monies in the form of grants and forgivable loans to complete the work.

Because the church had been providing and serving meals on the streets for five years prior to the opening of the new building, church volunteers had established interpersonal relationships with many of those who were chronically homeless due to
substance abuse and mental illness. As a result, when they were invited to receive services at the newly renovated building, the homeless readily accepted our invitation. The church began to provide counseling, Bible study, housing, job placements, and Sunday Worship Services.

Initially, the staff at the new facility called Odyssey III, all were volunteers from the congregation. The name Odyssey III was chosen because we realized that persons experiencing homelessness were on their own “odyssey.” Initially, there were three components of services being offered. These components were: prepared meals, case management and transitional housing. While offering these services, it became apparent that some of the people were suffering from chronic mental illness and would require more than a meal and shelter from the elements. This realization became the impetus for addressing the larger issue of homelessness and the need for mental health services for ministering to this population group.

**MOTIVATION FOR ADDRESSING THE ISSUE**

The motivations for addressing this ministry issue are broad and varied. To be sure, the church and its members have experienced deeply the significant events of the American historical experience. Among these are the experiences of the Vietnam War, the Civil Rights Movement, the de-institutionalization of the Mentally Ill, the Anti-Apartheid Movement, the death of Reverend Martin Luther King, Jr., and the institutionalizing of homelessness. While the Chapel of Christian Love Baptist Church (The Chapel) is relatively young, at thirty years old, it has come to realize that the world-view, character, and theological stance of the leadership of the church has been shaped by these events and more. It has been a church that has championed peace and justice issues
from the very start of its our existence. It has been deliberate about reaching out to those who are marginalized by politics and injustice. It has invested time and monies to fight injustice and to advocate for peace both locally and globally.

In addition, it must be recognized that the social attitudes of the larger social community of Atlanta and others began to change. This new social change shifted from relating to the mentally ill from the standpoint of a confinement paradigm to a more therapeutic mode as a church, the Chapel wanted to be a part of a therapeutic solution to the problem of homelessness and mental illness rather than focus on outdated punitive measures.

Further, as stated above, the motivation for addressing the issue of homelessness and mental health grows out of this church’s understanding of the biblical mandate. It believes that as Christians it ought to bear the infirmities of the weak. Paul states “We then that are strong ought to bear the infirmities of the weak, and not to please ourselves.” (Rom 15: 1 KJV.)

DEFINITIONS OF TERMS

**Homeless** – In order to fit into the official Federal and State definition of homelessness, a person must fall into one of several categories such as: (1) sleeping in places not meant for human habitation, or person is living in a shelter for less than two weeks. (2) sleeping in places not meant for human habitation and without assistance would have to sleep in a shelter or in a place not meant for human habitation. And those that have experienced these conditions continuously for more than a year are considered chronic.

**Chronic Mental Illness** – Psychiatric illness in which the symptoms persist consistently over an extended duration of time. After initial onset of the disorder, this type of illness is usually degenerative and is likely to continue to some extent, throughout the duration of an individual’s life.

**Safe Haven** – A Safe Haven is a form of supportive housing funded and administered under the HUD Supportive Housing Program serving hard – to – reach homeless persons with severe mental illness and debilitating behavioral conditions who are on the streets and have been unwilling or unable to participate in supportive services.
**Deinstitutionalization (of the mentally ill)** – A policy established in the 1980s that advocated discharge of psychiatric clients from restrictive, inpatient settings, in an effort to respect their rights to freedom of choice. This policy held that it was inhumane to keep patients hospitalized for years on end, with little self-determination as to how they lived their lives. However, the community was not prepared with enough appropriate settings to accommodate this wide-scale influx of formerly hospitalized psychiatric patients. The policy essentially “backfired” and resulted in the largest rise in the homeless population in history.

**Faith Community** – A term used to refer to the network of community churches, synagogues, mosques, and religious organizations.

**Symptomatic** – Currently displaying the designated symptoms of one’s mental illness.

**Non-symptomatic** – Not currently displaying the designated symptoms of one’s mental illness.

**Global Assessment of Functioning Scale** – A scale of psychological functioning that is used as a procedure for measuring overall severity of psychiatric disturbance.

**Transitional Housing** – A supportive housing setting that provides a conducive environment for making the necessary life changes in order to attain a greater level of self-sufficiency and independence. A consumer may remain in a transitional housing program for up to two years (per HUD regulations). A nominal fee is usually charged for participation in the program.

**Psychotropic Medication** – Any of a group of medicines specifically designed to address the chemical imbalance that exists when one experiences a psychiatric disorder.

**Emergency Shelter** – A temporary housing placement that exists to accommodate those in the homeless situation with absolutely no income/resources to attain housing. The accessibility of this form of housing is determined by: (1) the capacity and availability of beds, (2) getting to the shelter by the established intake time, (3) fitting into the criteria of the target population being served (i.e. – some places only serve men; some places only serve adults; etc.), (4) willingness to comply with the rules of that shelter.

**Antipsychotic Medications** – A psychotropic medication that particularly addresses symptoms of psychosis (i.e. – hallucinations, paranoia, delusions).

**Psychosis** – A psychiatric condition of instability marked by the occurrence of phenomena that inhibits one’s perception of reality. Symptoms of psychosis include hallucinations, paranoia, and delusions, or fixed false beliefs.

**Self-Medication** – A term used to describe the effort of a person to stabilize their psychiatric condition with the use of alcohol and street drugs. This also refers to the use
of prescription drugs in a way other than recommended (by prescribing psychiatrist/pharmacist).

**Half–Way House** – Refers to a type of housing designed to serve convicted criminals who are preparing to be released and are currently working in the surrounding community. It can also be used to refer to a type of housing designed to support those consumers recently released from an inpatient substance abuse program.

**Schizophrenia** – A brain disorder marked by an imbalance of the neurotransmitter serotonin, in the brain. Some symptoms that accompany this disorder are: isolation; depression; auditory/visual hallucinations; delusion; bizarre thinking; racing thoughts; blunted emotions; and difficulty making emotional attachments.

**Bipolar Disorder** – Formerly known as manic depression, this brain disorder results from an imbalance of neurotransmitters in the brain (dopamine; serotonin) and is marked by extreme mood swings from episodes of depression to episodes of mania. Other symptoms include insomnia, impulsive behavior, and anxiety.

**Voluntary Commitment** – Is when a consumer voluntarily admits themselves to a psychiatric institution for an allotted period of time. This is usually an indication that the consumer recognizes that they have psychiatric illness and have some level of insight into their illness. A consumer may leave his placement voluntarily on this type of commitment.

**Involuntary Commitment** – Is when the state takes the responsibility of admitting a consumer to a psychiatric institution for a court mandated period of time. The consumer must make a certain amount of progress with their treatment and be approved by staff and the court to be released from the institution.

**Peer Specialist** – Is a staff person who has also been a consumer of mental health/substance abuse services, is currently in recovery from those issues, and working to help others with those same issues. There is a certification process that peer specialists may undergo to become Certified Peer Specialists, thereby eligible to work with consumers throughout the state.

**Dual Diagnosis** – Is a term that refers to being diagnosed with both mental health and substance abuse issues. Rather than treating these issues separately, it has been found that treating both disorders concurrently tends to work better with this population.

**SUMMARY AND CONCLUSION**

The larger parish area for the Chapel of Christian Love Baptist Church consists of the local neighborhood of the church and the broader communities of the City of Atlanta,
Fulton and Dekalb Counties, but this ministry also serves individuals from all over the eight county metropolitan area. The perception that Atlanta is a land of opportunity for African Americans, and, indeed, is the “Black Mecca” is false for many African Americans. Many African Americans in poverty have been displaced by the removal of the public housing projects that, in turn, were replaced by mixed income housing. Laws prohibiting persons convicted of a felony from occupying new housing has further exacerbated the problem and caused many poor African Americans to move to other jurisdictions. Through the help of the Mayor and the City Council of Atlanta, there now exists the political will to seriously address the problems associated with low income housing and permanent housing with supportive services for the chronically homeless.

The Chapel of Christian Love Baptist Church defines its mission based on the theology that God champions the cause of the poor and afflicted. The church adopts the theology of the grace and judgment narrative found in the Gospel of Matthew 25:31-46. We affirm that the disposition of one’s soul is determined by their response to the needs of the hungry, the sick, the prisoner, and the stranger.

The organizational structure of the church reflects typical Baptist ecclesiology. Deacons function in spiritual roles, the pastor serves at the pleasure of the congregation, and as Executive Director of the Out-Reach Ministry, Community Concerns Inc., and Ministry Liaison to government, funding sources, the faith community and the community at large.

Social movements within the larger American community have shaped our vision along with our understanding of the biblical mandate. Interestingly, during the homeless census count of year 2005, there was not an inquiry made as to how many persons had a
diagnosis of mental illness. While there was no attempt to capture the numbers of homeless persons diagnosed with mental illness, it is believed by service providers to this population that at least 30% of homeless people would be included in this number. When we consider all persons experiencing homelessness, those diagnosed and those who have not been diagnosed, however, the number goes up dramatically.

In light of the church’s experience with justice issues and healing and therapeutic attitudes, it is believed that if it could identify and serve the population of chronically mentally ill persons who are experiencing homelessness the numbers of homeless persons in this ministry setting would be dramatically reduced. Those needing mental health services could receive the therapeutic services that would improve their health as well as break the revolving cycle of homelessness.

LIMITATIONS OF THE PROGRAM

This program has proven to be very successful in fulfilling its mission. It is the only such program in the entire State of Georgia. While the success of the program is apparent there are some limitations that are yet to be addressed. One such limitation is the lack of safe and affordable permanent housing to which the client may be transitioned. Such housing must have a supportive service component.

Another limitation is the length of time it takes a person to make application for Social Security benefits and the receipt of the first payment. Although persons diagnosed with a chronic mental illness are eligible and qualify for these benefits, the process to determine these qualifications hinders such persons from moving on to a more stable and permanent setting.
It was mentioned earlier in this writing that a lack of volunteers poses certain limitations to the client. These volunteers could be utilized to accompany the client to their appointments with the psychiatrist, social security office and to other places where they must conduct business.

Finally, money is always a determining factor in the level of success obtained in a program such as this. Adequate funding is a must. Without such funding the level and quality of service will decrease drastically. Additional funding would also increase our capacity to serve more clients.

There is an additional limitation posed by the gender restriction. The program serves only men presently yet there is as great need among women as well.
Chapter II

LITERATURE REVIEW

THEORETICAL AND PRACTICAL APPLICATION

This chapter reviews the empirical, theological, and biblical literature relative to the issue of homelessness and chronic mental illness. Practical application of this theoretical foundation for the ministry project is also discussed. In this way, the chapter seeks to synthesize and summarize the theoretical and practical approaches to this significant issue. A summary concludes the chapter.

EMPIRICAL LITERATURE REVIEW

As the author begins the review of the empirical literature addressing the issue of homelessness and mental illness, E. Fuller Torrey provides a significant starting point. Torrey’s study of the issue of mental illness and the chronic mentally ill, who are experiencing homelessness spans more than a decade of in-depth and extensive research.

In 1997, Torrey indicated that the estimated number of Americans with untreated severe mental illnesses was 2.2 million. He further states that approximately 150,000 of those with severe mental illness were homeless on any given day, living on the streets or in public shelters. Another 159,000 were incarcerated in jails and prisons, mostly, for crimes committed because they were not being treated for their illness.²

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²Ibid.
Torrey attributed this sad state of affairs to a lack of societal will to address these interrelated issues. He says, “Tragically, most of these instances of homelessness, incarcerations, episodes of violence, and premature deaths are unnecessary. We know what to do, but for economic, legal, and ideological reasons we fail to do it.”

In some instances, people were confined unnecessarily and against their wills. Abuse of patients did occur in many of these cases. Advocates of the rights of homeless and mentally ill patients sought to champion their cause and argued for more humane treatment and patients’ rights.

The mental health provider community responded to this advocacy with a new policy of moving severely mentally ill persons from large state institutions and then closing part or all of the facility. This process became known as deinstitutionalization and it is thought to have been a “major contributing factor to the mental illness crisis.” According to Torrey, “Deinstitutionalization began in 1955 with the widespread introduction of a drug known as Thorazine, the first effective antipsychotic medication.”

This policy received a major impetus ten years later with the enactment of federal Medicaid and Medicare laws. Deinstitutionalization has two parts: a) the moving of the severely mentally ill out of the state institutions, and b) the closing of part or all of those facilities. The former affects people who are already ill; the latter affects those who become ill after the policy has gone into effect and for the indefinite future because hospital beds have been permanently eliminated.

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3 Ibid.
4 Ibid., 8.
5 Ibid.
As Torrey chronicles the progression of the process of deinstitutionalization, we readily can see how the problem of mental illness and homelessness was exacerbated by this policy, he notes:

The magnitude of deinstitutionalization of the severely mentally ill qualifies it as one of the largest social experiments in American history. In 1955, there were 558,239 severely mentally ill patients in the nation’s public psychiatric hospitals. In 1994, this number had been reduced by 486,620 patients, to 71,619. It is important to note, however, that the census of 558,239 patients in public psychiatric hospitals in 1955 was in relationship to the nation’s total population at the time, which was 164 million. By 1994, the nation’s population had increased to 260 million. If there had been the same proportion of patients per population in public mental hospitals in 1994 as there had been in 1955, the patients would have totaled 885,010. The true magnitude of deinstitutionalization, then, is the difference between 885,010 and 71,619. In effect, approximately 92 percent of the people who would have been living in public psychiatric hospitals in 1955 were not living there in 1994. Even allowing for the approximately 40,000 patients who occupied psychiatric beds in general hospitals or the approximately 10,000 patients who occupied psychiatric beds in community mental health centers (CMHCs) on any given day in 1994, that still means that approximately 763,391 severely mentally ill people (over three-quarters of a million) are living in the community today who would have been hospitalized 40 years ago. That number is more than the population of Baltimore or San Francisco.6

One might conclude, therefore, that in an effort to address and correct the problem of mental illness and institutionalization, there was overkill; they threw the baby out with the bath.

In an earlier work entitled, Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill, Torrey highlights two issues of Life magazine that were issued exactly thirty five years apart. He believes these articles indicate the massive abuse suffered by many of the patients in mental health institutions and why such drastic measures as deinstitutionalization were accepted and embraced by the general public. The first article

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6Ibid., 9.
appeared in the May 6, 1946 issue entitled, *Bedlam 1946: Most US Mental Hospitals are a Shame and a Disgrace*:

Life magazine told it all in two issues exactly thirty-five years apart. May 6, 1946. *Bedlam 1946: Most U.S. Mental Hospitals Are a Shame and a Disgrace.* The author, Albert Q. Maisel, shocked America with an indictment of the nation’s mental hospitals more graphic and damning than anything previously published. The states, he said, had allowed their institutions for the mentally ill “to degenerate into little more than concentration camps on the Belsen pattern.” Conditions in the hospitals were said to be atrocious, with the quality of food being “what is usually found in most garbage cans” and food sometimes simply thrown on the table with “the patients expected to grab it as animals would.” Hospitals were described with no trained nurses at all and in which attendants, who had had no training, regularly gave medication to patients without orders from a physician.

The *Life* article contained excerpts from reports of conscientious objectors who had worked as attendants in the hospitals in place of doing military service; such reports and court records, it said, documented “scores of deaths of patients following beatings by attendants.” Descriptions of such beatings were included from the reports of the conscientious objectors, including one in which a handcuffed patient had been kicked by the attendants in the back of the neck as well as “in the genitals which caused the victim to scream and roll in agony.”

What was most shocking, however, was the pictures that accompanied the article, pictures of wards of completely naked patients, pictures of wards with beds so tightly packed that the floor was not visible, and especially a large, haunting, three-quarter-page picture that looked like a drawing done by William Blake to illustrate Dante’s *Inferno*. The picture was captioned: “These Byberry [Philadelphia State Hospital] male patients are left to live day after day sitting naked on refuse-covered floors without exercise or diversion.” It was the kind of picture that stayed with the reader long after that issue of *Life* had been discarded. It was the type of picture that would fundamentally change the venue, but not the manner, in which the seriously mentally ill are treated in America.  


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Without referring to the article of thirty-five years earlier, *Life* described in words and pictures the fate of patients who had been deinstitutionalized from state mental hospitals. There was William Hopkins, shown walking down the street in Springfield, Massachusetts, “hallucinating between fleeting moments of clarity, butting his head against store windows, pounding his forehead until it bleeds.” He had been admitted to and discharged from Northampton State Hospital ten separate times. Then there were pictures of Neal and Rita DeLuck, both discharged from the same mental hospital. Neal, diagnosed with schizophrenia, had been in and out of hospitals twenty-nine times, a classic revolving-door case. Neal and Rita were pictured living in an unheated attic of a halfway house run by another ex-patient. According to the article, both Neal and Rita had body lice and neither had changed clothes in two months. They described themselves as “two happenstance nuts who cling together.” Neal occasionally became violent because of his untreated illness and had once broken Rita’s jaw. Despite this Rita claimed that “all I have in the world is to look after him [and] empty his piss bottle...If he dies, I’ll kill myself.” The article asserted that two-thirds of similar individuals living in Springfield who needed psychiatric care were receiving none. The fate of such individuals was summarized by a psychiatrist who observed: “The majority gets dumped amid the broken promises.8”

As one can see by the picture painted by these two articles, drastic measures were called for. The plan was to discharge these patients from state-run hospitals and treat them in Community Mental Health Centers. The patients would be monitored and given medication to treat their symptoms.

It did not take long to realize, however, that this plan of action left much to be desired. Most of the patients were not competent enough to keep up with their medical and psychiatric appointments and self-medication posed a further problem for the patient, as well. In self-medication, patients attempt to stabilize their mental health symptoms through the use of street drugs and alcohol. Yes, drastic measures for change were called for, but it only resulted in wholesale dumping of patients on the streets of urban America.

8Ibid., 3.
As such, Torrey quotes an editorial from one of the nations leading newspapers as stating “deinstitutionalization has become a cruel embarrassment, a reform gone terribly wrong.”

Indeed, one might say that the policy of deinstitutionalization has been a complete failure. Nothing makes this fact more apparent than the fact that the majority of the mentally ill persons discharged from institutions have been officially lost. Nobody knows where they are and there are no follow-up records on those discharged.

State, Local, and Federal governments have long been in denial of the fact that many American citizens, who are counted among the chronically homeless, are persons with severe mental illness. In addressing this issue concerning the demographics of the homeless, Torrey says, “There is no question that large numbers of people have become homeless because of gentrification of the inner cities and the concomitant decrease in the number of rental units for low income families.” He also states that many of the homeless are persons recently released from jails without proper discharge procedures that could or would insure the person being released had a stable home, half-way house, or transitional home as a place of residence. He states, further, “nor is there any question that many of them [homeless] are newly arrived immigrants with no resources, alcoholics, and drug addicts who spend their rent money getting high,” many of these also suffer from disabling mental illness as well.

9Ibid., 5.
10Ibid., 6.
11Ibid., 8.
On December 31, 1987, a single page of the Washington Post carried a number of significant articles profiling the relationship between mental health, the break-down of consistent medication, violent crime and arrest prior to 1950. According to this report;

A Michigan man with a history of schizophrenia and refusal to take medication had murdered his two young sons; an Iowa man with a history of mental problems killed six members of his family; and an Arkansas man was placed in the state hospital in Little Rock for psychiatric evaluation after he had killed sixteen people. Now Torrey reports that scientific studies of arrest rates and violent acts by mentally ill persons prior to 1950, i.e. 1922, 1930, and 1945, unanimously show that mentally ill persons had lower current rates than the general population.

On the other hand, after deinstitutionalization began, since 1965 at least eight surveys of arrest rates and violent acts by mentally ill individuals found the rates to be much higher for this population group than for the general population.

In addition, The Community Mental Health Journal published in August 2002 found in a study that “African Americans are over-represented among homeless persons both in the general population and among the severely mentally ill and homeless.” The American Journal of Psychiatry also documented that, The prevalence of homelessness is associated with persons of male gender, African American ethnicity, presence of a substance use disorder, lack of Medicaid, a diagnosis of schizophrenia or bi-polar disorder, and poorer functioning. Not enough emphasis has been given to these facts and the contributing factors underlying them.

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12 Ibid., 18.
13 Ibid.
14 Ibid.
Relatedly, in an article in the *Journal of Health and Social Work*, David P. Moxley, Assistant Professor, School of Social Work, Wayne State University, and Paul P. Freddolino, Associate Professor, School of Social Work, Michigan State University, report on the self-perceived needs of homeless people who are coping with their psychiatric problems. Moxley and Freddolino specifically wanted to address barriers preventing homeless people with serious psychiatric disorders from using mental health services. They found these barriers included the threat of involuntary hospitalization, rigid expectations on the part of professionals for strict treatment compliance, lack of a connection between community mental health services and acceptable housing,16 ("Mechanic," 1987 see footnote 16), and stigma created by being labeled mentally ill (Solomon, 1988). Moxley and Freddolino concluded that successfully serving this demographic group requires "social workers to change the manner in which mental health services typically are delivered."17

On the basis of their review of 10 studies funded by the National Institute of Mental Health (NIMH), that have provided the best evidence to date on how to serve this population, R. C. Tessler and D. L. Dennis, identified several necessary characteristics for successful mental health services. First, these services should address basic needs, including food, housing, income, and legal needs. Second, service priorities must be based on needs as perceived by the consumers and not solely on needs the providers believe are important. Third, services must be integrated with a wide range of affordable


17Ibid.
housing options accompanied by various treatment compliances. Finally, workers should maintain continuity of relationships with clients across different residential and program settings to avoid losing the clients. In their view, “To create acceptable services for people coping with homelessness and serious mental health problems, social workers must understand how these people perceive their needs as well as how they define their preferences for support.”

This is not to state that government, mental health services providers, and advocates for the mentally ill must relinquish the practice of involuntary commitment altogether. In many instances, this practice is essential for the health and welfare of mentally ill persons, their families and society at large. The work of Torrey addressed this issue, as well, however, when he stated “laws designed to protect the rights of the seriously mentally ill primarily protect their rights to remain mentally ill.” As a consequence, the effort to protect the rights of the mentally ill has resulted not only in the mentally ill persons not getting the medical treatment they so desperately need, it frequently helps to justify the wholesale dumping of these persons resulting from the policy of deinstitutionalization. Now that we have dumped them literally on the streets, it’s next to impossible to find them and provide the treatment they need to live a stabilized life.

Again, Torrey states, “The laws governing involuntary commitment of the mentally ill in most states require that persons be demonstrably dangerous to themselves

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19 Torrey, Nowhere To Go, 29.
or to others."\textsuperscript{20} To be sure, Torrey recognizes that the term "dangerous" is relative and its interpretation is frequently left solely to the local police and judges and often without input from mental health service providers. In this case, local police and judges usually agree to involuntarily commit someone only when they are threatening to kill themselves or others. As an example of this situation, Torrey recounts an instance of a mentally ill person in Washington, D.C. and how this policy affected her:

In Washington, D.C., an attractive young woman was observed by a newspaper reporter panhandling in the city’s train station. On talking to her he learned that she was a college graduate and had been recently released from a psychiatric hospital. Her conversation did not make sense and she was hallucinating. A policeman was persuaded to take her to St. Elizabeth’s Hospital for possible commitment. The admitting psychiatrist, however, refused to commit her saying that she had not demonstrated dangerousness to self or others. A few days later she was found raped and murdered in an alley near the train station.\textsuperscript{21}

Finally, Torrey states:

"The changes in state commitment laws that took place in the 1960’s and 70’s, making involuntary commitment much more difficult, were created with the best of intentions. Well-meaning civil liberties lawyers, often working with the American Civil Liberties Union or the Mental Health Law Project, believed they were protecting individuals from unnecessary and sometimes endless incarceration and many lawyers advocated the complete abolition of involuntary commitment. But serious mental illnesses like schizophrenia are brain diseases in which parts of the brain are not functioning normally. The brain is the organ we depend upon to think about ourselves and to appreciate our need for help. Since the organ is impaired, it makes little sense to insist that only those persons should be treated who want help and ask for it. As one

\textsuperscript{20}Ibid., 30.
\textsuperscript{21}Ibid., 31.
observer phrased it, 'we are protecting the civil liberties [of the mentally ill] much more adequately than we are protecting their minds and their lives.'

**THEOLOGICAL LITERATURE**

The theology of a person, a church, a religious denomination is developed in many ways. Of these ways, James W. Fowler in his work entitled: *Stages of Faith: The Psychology of Human Development and the Quest for Meaning* and David J. Bosch in his work *Transformation Mission* are especially appropriate for addressing the ministry issue of homelessness and chronic mental illness.

Fowler seeks to draw an analogy between our faith and our relationships. He argues that, "Our first experience of faith and faithfulness begins with birth."

He attempts to demonstrate that those who care for us, welcome and receive us, and provide for our needs, establish a place of value for us in our and their lives. These acts of care, lay the ground-work for the claim that through this relationship we develop trust and loyalty to our care givers, thereby, creating faith that they will continue these provisions.

Notice that even in this rudimentary form faith exhibits what we may call a covenantal pattern of relationship. In the interaction of parent and child not only does a bond of mutual trust and loyalty begin to develop, but already the child, albeit on a very basic level, senses the strange new environment as one that is either dependable and provident, or arbitrary and neglectful. This covenantal pattern of faith as relation comes clearer as we reflect on what the parent or parents bring with them to the care and nurture of the child. They bring their way of seeing and being in the world. They bring their trusts and loyalties. They bring their fidelities-and infidelities-to other persons and to the causes, institutions and transcending centers of value and power that constitute their lives' meanings. Long before the child can sort out clearly the values and beliefs of the parents, he or she senses a structure of meaning and begins to form nascent images ... of the centers of value and power that animate the

22Ibid.

parental faith. As love, attachment and dependence bind the new one into the family, he or she begins to form a disposition of shared trust and loyalty to (or through) the family’s faith ethos.24

Fowler states that selfhood is made possible because there is a two-way flow between the self and others in which love, mutual trust, and loyalty flows. He says “this awareness of self and others produces the family’s shared center of value and power which discloses the essential covenantal pattern of faith as relational.”25

Fowler argues that all lasting human associations will exhibit something approximating this covenantal pattern of shared center of value and power. Fowler believes, “The vast web of commercial interdependence by which an urban society provides basic necessities for its population depends upon at least tacit fiduciary covenants at many levels.”26

It is interesting how Fowler sees covenantal relationships and commitments to persons, causes, institutions or gods out of a sense of “ought.” “We invest or devote ourselves because the other to which we commit has, for us, an intrinsic excellence of worth and because it promises to confer value on us.”27

This theology rings true in that people serve the causes, people and institutions they serve in hopes of pleasing God, becoming more valuable in the cause of Christ, and, as a result, appear more valuable to God. That, however, is not the sole motivation for such service. Yet, Fowler asserts the idea that “Our commitments and trusts shape our identities. They determine (and are determined by) the communities we join. In a

24Ibid., 17.
25Ibid.
26Ibid.
27Ibid., 18.
real sense, he says, we become a part of that which we love and trust. ‘Where your
treasure is, there will your heart be also,’ Jesus said.”

Fowler continues to build his case by comparing and contrasting the terms
“Polytheist” and “Henotheist” to characterize patterns of faith. He says the Polytheist
“lacks any one center of value and power of sufficient transcendence to focus and order
one’s life . . . The polytheist has interest in many minor centers of value and power.”

Fowler compares this pattern of faith to what he calls the henotheistic (Greek, *heno*,
“one” *theos*, “god”), trust in and loyalty to one god.”

Note that Fowler uses the un-capitalized “g” as he refers to the gods of the
polytheists and the god of the henotheist. This is because he is referring to the “gods”
we create as we commit ourselves to such a degree that such activity or objects of our
commitments become ones’ god or gods, depending on the characterization in which
one falls. Fowler suggests that one can become so henotheistic that our occupation,
either doctor, clergy, or, lawyer, defines who and what we are to the extent that we “end
up in our worshipping at an altar on which sits the faintly smiling image of our own
ego.”

Fowler, nonetheless, reveals that he also recognizes that henotheism has more
noble forms:

Henotheism also has more noble forms. Institutions and causes that elicit
selfless sacrifice and virtually total commitment are often worthy tribal
gods. For some good causes to make their proper impact on history,
Nietzsche somewhere suggests, they have to be loved by a few people for
far more than they are worth. Nations, churches, universities, political parties, the liberation and empowerment of minorities, even (or especially) philosophies and ideological movements, are all potential henotheistic centers of value and power. There are many others. In this more noble form of henotheistic faith, identity is found in losing the self in the service of a transcendentally important, if finite, cause.\textsuperscript{32}

In concluding his thoughts on faith and relationship, Fowler introduces a third faith-identity relational pattern he calls \textit{radical monotheism}.\textsuperscript{33} While recognizing that monotheism has traditionally meant the doctrine or belief that there is only one God, Fowler broadens the use of this term. He defines this radical monotheism and his use of it as follows:

Radical monotheistic faith calls people to identification with a universal community. This does not negate or require denial of our membership in more limited groups with their “stories and centering values.” But it does mean that our limited, parochial communities cannot be reserved and served as though they have unlimited values. Our potentially henotheistic centers of value and power can be loved with a proper and proportionate devotion.\textsuperscript{34}

Having said this, Fowler acknowledges that this radical monotheistic faith rarely finds consistent and long lasting actualization in persons or communities and people ultimately “feel the pull towards henotheistic and polytheistic forms of faith.”\textsuperscript{35}


\textsuperscript{32} Ibid.

\textsuperscript{33} Ibid.

\textsuperscript{34} Ibid., 23.

\textsuperscript{35} Ibid.
issues of faith from infancy, early childhood, adolescence and adulthood noting that each of these developmental stages opens opportunities and challenges for faith development beginning in the “pre-faith” period of infancy to the developmental possibilities offered by childhood, adolescence and, finally, adulthood.

In the section on “Stages of Faith,” Fowler identifies six developmental stages. These stages are: 1) Intuitive-Projective Faith, 2) Mythic-Literal Faith, 3) Synthetic-Conventional Faith, 4) Individuative-Reflective Faith, 5) Conjunctive Faith, and 6) Universalizing Faith. In turn, these stages are coordinated with the human developmental stages in the following manner. Intuitive-Projective Faith, i.e., faith represented by those to whom the child is primarily related is characteristic of ages three through seven. The stage, Mythic-Literal Faith, is the stage characterized by the school child (though sometimes found to be dominant in adolescents and in adults) in which the child appropriates the stories, beliefs and observances of his or her community. In stage three of Fowler’s typology, there appears to be an indication that persons in this stage of faith development find their faith stance dictated primarily by “significant others.” This significant other may be a peer group, parents, or, even the primary ideology of the community in which one resides. A person at this stage will not hold to values based on his or her analysis of a thought or idea, but will tend to adopt the generally held position of the parents, peers or overall community. Persons at this stage would not be interested in Bible studies that challenged long held beliefs passed on to them from generation after generation. Rather, a person of this type is more characteristic of stage three—the Synthetic-Conventional level of faith. Fowler states, “this is the central meaning behind the terms synthetic and conventional: the stage three individual’s faith system is
conventional, in that it is seen as being everybody’s faith system or the faith system of the entire community. And it is synthetic in that it is non—analytical; it comes as a sort of global wholeness.”36

A good example of stage three faith is seen in the colloquial pass and repass, where a minister says “God is good” to the congregation and the usual reply is, “All the time;” the lead person then says, “All the time,” and the congregation replies, “God is good!” Any attempt at demythologization is met with resistance at stage three. There is a level of comfort at this stage, however as Fowler states:

... stage three typically has its rise and ascendancy in adolescence, but for many adults it becomes a permanent place of equilibrium. It structures the ultimate environment in interpersonal terms. Its images of unifying value and power derive from the extension of qualities experienced in personal relationships. It is a conformist stage in the sense that it is acutely tuned to the expectations and judgments of significant others and as yet does not have a secure enough grasp on its own identity and autonomous judgment to construct and maintain an independent perspective.37

In stage four of these stages of faith, there is movement from positioning ones’ thoughts that were reflective of the family, group or community into a more individuated thought pattern. Fowler believes in stage four,

there must be, ... a relocation of authority within the self. While others and their judgments will remain important to the Individuative-Reflective person, their expectative advice and counsel will be submitted to an internal panel of experts who reserve the right to choose and who are prepared to take responsibility for their choices. I sometimes call this the emergence of the executive ego.38

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36Ibid., 167.
37Ibid., 173.
38Ibid., 179.
While stage four usually takes place in young adulthood, according to Fowler, many adults do not reach this stage until their mid-thirties or forties, if at all.

Stages five and six, Conjunctive Faith and Universalizing Faith, are described by Fowler as a passage from the previous stages by the ability to see, in stage five, the relativity of one’s own symbols and stories as well as those of others yet still find meaning in both. Stage five is a divided stage due to this relativity and usually occurs in mid-life. Stage six, however, tends to move beyond the relativity and irony one experiences in mid-life to an affirmation of the transcendent reality that one has experienced earlier and sees experienced by others. It gives itself to the possibilities of the future which transcendence is working out eschatologically. Universalizing faith leans toward the future and the possibilities transcendence intends for the created order.

In outlining these stages of faith development, Fowler provides individuals, congregations and ministry leadership with a diagnostic typology, to be sure, but, more importantly a typology for the development of faith and a road map for ministry and missiology. Before one can undertake a mission project of the scope of the Chapel of Christian Love Baptist Church, a ministry to the homeless and mentally ill, one must understand the “faith dynamics” of the leadership and the congregation.

In our case, the congregation was primarily at stage four, Individuative—Reflective Faith, in Fowler’s typology. Not all were or are there; some still remain at stage three, Synthetic—Conventional Faith, but the general attitude of the leadership and most of the congregants is that of stage four. It is quite apparent and operational. They are prone to examine closely their faith stance and be critical of what they believe and why they believe it.
This stage is evident in the unconventional approach to ministry adopted by the leadership of the Chapel of Christian Love Baptist Church and the congregation’s willingness to follow and participate in the ministry. Stage three would have relegated them to a study and knowing of the need for the church to engage in ministry to the poor at some level. The unconventional mode of the Chapel of Christian Love caused that congregation to not only study and know, but to invest all its resources and involve all its people at some level to doing what they came to recognize as the desire of God. In this respect, they appear to be growing to the universalizing faith of Fowler’s stage six. That the budget for this out-reach ministry more than doubles the budget for the worship and operation of the church itself appears to more than confirm this fact.

In considering this “unconventional” ministry and comparing it with others and ministries of the past, David J. Bosch has been helpful in his work entitled, *Transforming Mission*. Bosch strongly argues that there are necessary paradigm shifts that are taking place in the theology of mission. Moreover, these paradigm shifts have had a significant impact on our mission project related to the homeless and mentally ill. In *Transforming Mission*, Bosch argues that there must be a refocusing of emphasis, if missiology is to measure up to its true calling. He says, “The modern gods of the western civilization—science, technology, and industrialization-have lost their magic”\(^{39}\) as prescriptive means for solving the human problems of society.

Bosch contends that modern progress in the West has in fact become a false god. Bosch cites the world events such as “two devastating world wars, the Russian and Chinese revolution, the perpetrated horrors by rulers of countries committed to national

socialism, and fascism, communism, and capitalism; the collapse of the great Western colonial empires, the rapid secularization of the West and large parts of the rest of the world, the increasing gap world-wide between the rich and the poor, and the realization that we are heading for an ecological disaster on a cosmic scale\textsuperscript{40} all testify to the failures of so-called modern progress to solve existential human needs. Bosch notes, therefore, that the conclusion of many, including Christians, is that “the Christian mission and everything for now belong to a bygone era. It should be eulogized and then buried.”\textsuperscript{41}

Bosch and others, however, argue that the Christian church is missionary by its very nature and should repent of the past mistakes and not relinquish the important work that is yet to be done. Rather, the Christian church simply needs to learn to do missiology differently. The Chapel’s view concurs with and believes the faith community as a whole, Christian and non-Christian a like, must champion the cause of the poor, the oppressed and the mentally and physically ill.

In the section “Mission as a Quest for Justice” in Transformation Mission, Bosch states of evangelism, “it will be argued that although evangelism may never simply be equated with labor for justice, it may also never be divorced from it. The relationship between evangelistic and the societal dimensions of the Christian mission constitutes one of the thorniest areas in the theology and practice of mission.”\textsuperscript{42}

One can conclude that Bosch is making a case for the paradigm shift of the church from simply trying to get people into heaven through Jesus to trying to get the essence of

\textsuperscript{40}Ibid.

\textsuperscript{41}Ibid., 365.

\textsuperscript{42}Ibid., 401.
Jesus into the people of the church as he champions the cause of justice, lifting the burdens of the oppressed and setting the captives free. To emphasize this, Bosch says, "in the Protestant ecumenical movement, and to a lesser extent in contemporary Catholicism, it seems the prophetic motif predominates. In some manifestations of ecumenicalism, however, it seems that the rational ethic which aims at justice is more powerful than the religious ethic of love. The Social Gospel, for instance—particularly after the year 1900—emphasized social concern in an exclusivistic way which seemed to undercut the relevance of the message of eternal salvation." This is not to say, however, that the social gospel has stripped the gospel of its importance, but that the gospel of Jesus is incomplete without the social gospel.

Thus, in Bosch's chapter entitled, "God's Preferential Option for the Poor," he states:

Two hundred years after the Enlightenment, . . . We live in a world in which millions of people enjoy a standard of material wealth that few Kings and Queens could match then. As this wealth accumulated, rich Christians increasingly tended to interpret the biblical sayings on poverty metaphorically. The poor were the poor in spirit, the ones who recognized their utter dependence upon God. In this sense, then, the rich could also be poor—they could arrogate all biblical promises to themselves."

Too many Christians, though not rich, are just as unwilling to see the poor and their unmet needs. They become the walking dead, totally invisible and voiceless.

The biblical text mandates the Church and the followers of Jesus Christ to address the needs of the people, both spiritual and physical. This can be seen from the outset of Jesus' ministry. Not only does he minister to others, but he also evangelizes a team of twelve and exhorts them to ministry as disciples and apostles.

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43 Ibid., 402.
44 Ibid.
Jesus is very clear as to the mission of his disciples. These disciples leave their daily occupation, seemingly place their families subordinate to his mission, and devote themselves to going out and attending to the tasks at hand. Jesus is clear that they are first to proclaim the good news that the kingdom of heaven has now come near and then they are to heal the sick (Lk 9:1ff.). These are the primary objectives of their going out into the communities of the people of Israel. Initially, they directed their efforts to those who were believers of the God of Abraham. We learn later that Jesus' mission would be directed to all people that they might also believe and be healed.

In Luke 9:1-2, we find Jesus calling twelve men and empowering them with authority over all demons and diseases. His instructions to them were to go and proclaim the kingdom of God and to heal. Their objective was to lead people to repentance and display the mercy of God through their powers of healing.

Obviously, in the text, this service of healing was so important that Jesus contends that the very disposition of their souls would be determined by how they respond to those found in need of food, water, clothing, healing and those imprisoned as we see in Matthew 25: 31-46.

In Matthew we find a narrative depicting the judgment of the end—time and how it will impose punishment or reward. This judgment narrative is actually the conclusion to an inquiry made by Jesus' disciples:

When the son of Man comes in his glory, and all the angels with him, (Jesus states) he will sit on his throne in heavenly glory. All the nations will be gathered before him, and he will separate the people one from another as a shepherd separates the sheep from the goats. He will put the sheep on his right and the goats on his left. Then the King will say to those on his right, 'Come, you who are blessed by my Father; take your inheritance, the kingdom prepared for you since the creation of the world. For I was hungry and you gave me something to eat, I was thirsty and you
gave me something to drink, I was a stranger and you invited me in, I
needed clothes and you clothed me, I was sick and you looked after me, I
was in prison and you came to visit me.’ Then the righteous will answer
him, ‘Lord, when did we see you hungry and feed you, or thirsty and give
you something to drink? When did we see you a stranger and invite you
in, or needing clothes and clothe you? When did we see you sick or in
prison and go to visit you?’ The King will reply, ‘I tell you the truth,
whatever you did for one of the least of these brothers of mine, you did for
me.’ Then he will say to those on his left, ‘Depart from me, you who are
cursed, into the eternal fire prepared for the devil and his angels. For I
was hungry and you gave me nothing to eat, I was thirsty and you gave me
nothing to drink, I was a stranger and you did not invite me in, I needed
clothes and you did not clothe me, I was sick and in prison and you did not
look after me.’ They also will answer, ‘Lord, when did we see you hungry
or thirsty or a stranger or needing clothes or sick or in prison, and did not
help you?’ He will reply, ‘I tell you the truth, whatever you did not do for
one of the least of these, you did not do for me.’ Then they will go away to
eternal punishment, but the righteous to eternal life. (Matthew 25:31-46
NIV).

At the Chapel of Christian Love Baptist Church we believe that this narrative
(Matthew 25:31-46) was not simply given for information alone, but was given as a
charge to his disciples and to us as the Church at large, today. Just as Jesus had charged
the disciples from the outset to go forth and proclaim that the kingdom of heaven is near
at hand, and, admonish the people to repent, he also charged them to heal the sick.
Matthew 25:31-46, therefore, simply expands the charge and specifies more clearly what
the disciples of the early Church and subsequent followers of Jesus are to do.

Jesus not only expands his mission and that of the original disciples, but in Luke
10:1-16 we find Jesus expanding the number of disciples. We are told in this passage
that Jesus appointed seventy beyond the twelve and sent them out in teams of two. In
Luke 10:9, we find Jesus giving the same instructions that he gave the twelve: “Heal the
sick who are there and tell them the kingdom of God is near you.”(Luke 10:1-16 NIV)

Jesus, moreover, in this context emphasized the consequences of those who would reject
these disciples and the benefits to those who would hear them. The disciples are
instructed to allow their peace to rest upon the worthy house or city and to shake the dust
off their sandals if they are rejected.

From the text, it appears that these seventy disciples had a successful ministry
campaign. When they returned, they declared ascetically, “Lord, even the demons submit
to us in your name,” (Luke 10: 17 NIV). The record says they were filled with joy. Jesus
reminded them that he had given to them the ability and the authority to overcome the
power of the enemy, but Jesus also cautioned them not to rejoice because the spirits
submitted to them, don’t celebrate because you were victorious over demons, instead,
rejoice that your names have been written in heaven. This, again, emphasizes the fact
that obedience to the charge given by Jesus results in positive and negative dispositions
with respect to one’s soul.

It is very important to point out in this context that Jesus did not just send others
to proclaim the kingdom of God and to heal, but he demonstrated how this was to be
done and its consequences for those who were healed. One such occasion that illustrates
this point is found in Luke 8:26-39, here Jesus and the disciples:

... sailed to the region of the Gerasenes, which is across the lake from
Galilee. When Jesus stepped ashore, he was met by a demon-possessed
man from the town. For a long time, this man had not worn clothes or
lived in a house, but had lived in the tombs. When he saw Jesus, he cried
out and fell at his feet, shouting at the top of his voice, “What do you want
with me, Jesus, Son of the Most High God? I beg you, don’t torture me!”
For Jesus had commanded the evil spirit to come out of the man. Many
times it had seized him, and though he was chained hand and foot and kept
under guard, he had broken his chains and had been driven by the demon
into solitary places. Jesus asked him, “What is your name?” “Legion,” he
replied, because many demons had gone into him. And they begged him
repeatedly not to order them to go into the Abyss. A large herd of pigs
was feeding there on the hillside. The demons begged Jesus to let them go
into them, and he gave them permission, When the demons came out of
the man, they went into the pigs, and the herd rushed down the steep bank into the lake and drowned. When those tending the pigs saw what had happened, they ran off and reported this in the town and countryside, and the people went out to see what had happened. Whey they came to Jesus, they found the man from whom the demons had gone out, sitting at Jesus’ feet, dressed and in his right mind; and they were afraid. Those who had seen it told the people how the demon-possessed man had been cured. Then all the people of the region of the Gerasenes asked Jesus to leave them, because they were overcome with fear. So he got into the boat and left. The man from whom the demons had gone out begged to go with him, but Jesus sent him away, saying, Return home and tell how much God has done for you. So the man went away and told all over town how much Jesus had done for him. (Luke 8:26-39 NIV).

Note that this narrative is related to both the sending out of the twelve and, subsequently, to that of the sending out of the seventy. In this narrative, we find Jesus sailing to the island of the Gerasenes. As he steps on shore, he encounters a demon-possessed man who is also referred to as a lunatic. The text states that the man wore no clothes, but would tear the clothes off his body, and he lived among the tombs. As such, he had no home in the traditional sense, rather, only a cemetery—the land of the dead as home. By analogy, today, this man could or would be considered homeless and chronically mentally ill.

Further, while the community responded to this man by trying to restrain him with chains and fetters, Jesus’ response to him was to free him with love and compassion. Jesus healed him and reintegrated him back into community. This becomes apparent in that, when the town’s people came to investigate Jesus’ activities with this man, they found him disposed of his demons, sitting calmly at Jesus’ feet, dressed in clothing, and in possession of his right mind. The message that the town’s people experienced, no doubt to their surprise, was that the lunatic had been cured. Moreover, the healed man was so grateful that he too desired to follow Jesus and to become a part of his ministry.
Jesus, however, asked the man to go back to the people who had once feared him, mocked him and restrained him and tell them what God had done for him. The man obeyed and went and told all the people how much Jesus had done. The consequence of this healing, therefore, led to the reintegration of the demoniac into his society with a ministry of discipleship.

The healing of the demoniac and his reintegration into community is by no means an isolated case. We see the same motifs over and over again in the gospels. Luke 17:11-19, records an occasion when Jesus was passing through a region between Samaria and Galilee. Here, Luke mentions lepers approaching Jesus. As they approached, they took precautions to maintain a certain distance as required by law of those stricken with this disease. In doing so they were following the law that required a priest to determine their state of cleanliness or un-cleanliness. Jesus hears their plea for healing. As such, the text states:

They stood at a distance and called out in a loud voice, “Jesus, Master, have pity on us!” When he saw them, he said, “Go, show yourselves to the priests.” And as they went, they were cleansed. One of them, when he saw he was healed, came back, praising God in a loud voice. He threw himself at Jesus’ feet and thanked him—and he was a Samaritan. Jesus asked, “Were not all ten cleansed? Where are the other nine? Was no one found to return and give praise to God except this foreigner?” Then he said to him, “Rise and go; your faith has made you well.” (Luke 17:11-19 NIV).

Jesus instructs the lepers to go to the priest and present themselves. While they are in route to the priest, they note that the spots on their skin had dried up; healing had taken place. No longer were they unclean, but now could be allowed to re-enter the community on the pronouncement of the priest and prescribed sacrifice.
Further, Jesus’ compassion for those ostracized by the community can be seen in his response to the woman who was hemorrhaging while enduring an illness for twelve years. She, undoubtedly, had heard of Jesus’ ability and willingness to heal. Because of her condition, she would have been denied access to the temple for worship. In short, she was considered unclean. She was determined to contact Jesus, believing that if she could simply touch him, healing would take place. Many have wondered and debated the source of the woman’s healing, but in the text Jesus states that her faith had healed her. Jesus states, “Take heart daughter, your faith has healed you. And the woman was healed from that moment.” (Matthew 9:20-22 NIV). Importantly, one should note, that this healing meant more than the simple absence of illness on the woman’s part—it allowed her to re-enter society as a whole person.

Again, this theme, Jesus’ healing and returning the persons back to society, is seen in John 5:1-9a. Here we read that:

Some time later, Jesus went up to Jerusalem for a feast of the Jews. Now there is in Jerusalem near the Sheep Gate a pool, which in Aramaic is called Bethesda and which is surrounded by five covered colonnades. Here a great number of disabled people used to lay—the blind, the lame, the paralyzed. One who was there had been an invalid for thirty-eight years. When Jesus saw him laying there and learned that he had been in this condition for a long time, he asked him, “Do you want to get well?” “Sir,” the invalid replied, “I have no one to help me into the pool when the water is stirred. While I am trying to get in, someone else goes down ahead of me.” Then Jesus said to him, “Get up! Pick up your mat and walk.” At once the man was cured; he picked up his mat and walked. The day on which this took place was a Sabbath.45

The similarity between this story and the healing of the hemorrhaging woman is evident, at first glance, in the longevity of the sickness both endured. Narratively, it appears, however, that the man’s faith was more in the process of the pool rather than in Jesus. In

45 John 5:1-9a NIV.
spite of this, Jesus spoke wellness to this man as he did to the woman with the issue of blood. She became healed the moment Jesus spoke the words, “Your faith has healed you,” and the paralytic was healed once Jesus commanded him to pick-up his mat and walk. Subsequently, in John 5:14 we learn that the healed man is seen at the temple and Jesus speaks of his wellness. This man is no longer confined to the colonnades near the Sheep Gate outside the city. Instead, he is now a participant of the populace as they gathered and worshiped in the temple. Once more, we see that the themes of healing and reintegration into society are interwoven themes that describe Jesus’ ministry in the gospels.

**SYNTHESIS AND SUMMARY**

After reviewing the empirical, theological and biblical literature, it is clear that the issue addressed in this paper is not new. We have seen from the empirical literature that deinstitutionalization of the mentally ill from American hospitals has exacerbated the problem of homelessness. We have seen that faith, Christian faith, is not static but developmental. The biblical literature has demonstrated that health, healing and restoration to society is the mission of Jesus and those who follow him. Indeed, it is his charge to the church universal. In confidence then, even when faced with what appears to be an overwhelming problem, homelessness and mental illness, the Church faces the question—“Is anything too hard for God?” (Genesis 18:14 NIV). The practical application for these discoveries, “the transforming mission,” is to empower the local church to become the catalysis through which God continues to address the needs of those who are ill physically and mentally and to set free those who are held captive by these conditions.
CHAPTER III

OBJECTIVES OF THE PROGRAM

The primary objective of addressing the issue of intervention on behalf of the chronically mentally ill who are experiencing homelessness is to create a better quality of life for them. This was achieved by doing several things, however, as we learned, there must be a priority in the doing for others.

The first thing to do in an undertaking of this type was to think through a way to reach the targeted group. While we initially identified the group as the chronically mentally ill who are homeless, a more definitive description is needed. Will this group encompass “all” mentally ill persons who are homeless, will it be confined to those who are “chronically” mentally ill and homeless, will there be gender restrictions, and, or, will there be age restrictions? All these questions must be answered before one can develop a nurturing, therapeutic program of Christian outreach for the mentally ill experiencing homelessness. Further, where would there be a suitable place to conduct this program and how does one market the services offered? The staffing and budgeting needs for the program must be determined as well.

Our decision was to target adult males who were suffering from a chronic mental illness and experiencing homeless. The out-reach effort was informed by the service providers to the homeless, the county hospital and local jails as well as the regional state hospital for the mentally ill. This determination helped to identify other people with whom to work and support our efforts.
At the outset, we recognized the need for an in-take person to do the initial needs assessments of the prospective clients. This person would refer the client to the central admittance office at Grady Hospital (the largest governmental, service hospital in the city of Atlanta and the State of Georgia) in order to connect them with the states' mental health systems. Secondly, this person oversaw the receipt of a diagnosis of the client’s condition, and, thirdly, after a diagnostic assessment the in-take person insured that the applicants were given appropriately, prescribed medication.

If the prospective candidate was already under the care of a psychiatrist, he would be given an application to be completed by the psychiatrist to inform the provider of diagnostic information and indicate the medication the client had been prescribed. As such, a psychiatric case manager who reviewed the application and client’s clinical information was used to assess the candidate’s appropriateness for the program. This person would also examine the criteria for residence and participation in the program.

Once the person was accepted and approved for placement in the program, the psychiatric case manager assigned the client to a designated room and paired him with a suitable roommate. This case manager met weekly with the client in group, and individual therapeutic sessions. Ultimately, this case manager conducted periodic evaluations and reviewed the progress to determine the client’s level of readiness for transition to a more permanent housing placement. In addition, the psychiatric case manager is responsible for the maintenance and confidentiality of all psychiatric forms and evaluations in accordance with the Health Insurance Portability and Accountability Act.
The next category of persons who worked with the program was the residential support staff. There were five such persons: one worked Mondays through Fridays from 5:00 p.m. to 1:00 a.m., another from 1:00 a.m. to 9:00 a.m., Mondays thru Fridays, and three supportive staff persons worked on the weekends. One worked 9:00 a.m. to 5:00 p.m., one from 5:00 p.m. to 1:00 a.m. and other from 1:00 a.m. to 9:00 a.m., Saturdays and Sundays.

The residential support staff was responsible for reviewing rules and regulations of the program with the client and insured that there was a thorough understanding of their rights and responsibilities as residents. They monitored the various clients self-administration of medication and documented their activity in the medication administrative log. This staff facilitated evening group therapy sessions and they were available for crisis intervention, as well.

A peer specialist was also a part of the program. The peer specialist provided essentially the same services as the residential supportive staff but from a client’s perspective. This person was one who had received mental health and homeless services previously and was stabilized. He provided an empathic approach based on his own personal experience.

The program provided a greater level of support for the client through the use of their life-skills trainer and a life-skill support staff. The life-skill trainer facilitated evening education groups on a range of topics designated to enhance a better quality of life. These topics included: personal hygiene, food preparation and cooking, housekeeping, personal laundry, accessing community services, utilizing public transportation, and basic residential maintenance. The life-skill support staff was
available to monitor the performance of assigned tasks in the morning breakfast program. In addition, this staff person also monitored the performance of the daily chores assigned to residents. He also monitored the cleanliness of the client’s personal living space and he accompanied the residents on group outings as needed.

A dietician was employed to insure nutritious meals and appropriate menus for the residents based on their particular dietary restrictions. This person selected the food commodities necessary to adequately provide meals and snacks.

A night manager was hired to provide security during evening and night operating hours. The night manager monitored the client’s adherence to the designated curfew hours and addressed behavioral patterns that were unacceptable for the communal living environment. He made hourly rounds to secure the facility and to insure that non-participants were not on campus. The night manager also administered random drug and alcohol screenings as needed.

A director of counseling was employed to give supervision and oversight for the above-mentioned staff and programmatic activities. This director has the responsibility for ongoing training and placement of residential candidates.

With the staff in place, we experienced the need for on-going funding and budgeting issues for the program. Partial funding was already in place through the federal government, but more would be needed to implement full staffing of the program. Additional funding was secured from state and local governments to insure full implementation of the program. The budget totaled over three-hundred thousand dollars annually.

The following diagram illustrates the candidate intake and placement process.
Diagram 1
Upon admittance into the program, the client received orientation into the program and an introduction to the staff. He was assigned a case manager and a room. The case manager then gave a Dual Diagnosis Assessment (drugs and alcohol) followed by a Daily Living Activities assessment to determine the candidate's living-skill level. The client would then participate with the service team members to develop an Individualized Service Plan. Weekly therapeutic group sessions were held as well as individual counseling sessions.

The available services of the program fall under the three categories reflected in diagram 2. They include residential support, psychiatric case management and therapeutic groups. The consumer of these services received the following under the category of Residential Support: daily monitoring of medications; co-facilitation of group held in evening hours; group outing and activities; daily observations of interactions and progress noted in file. Under the category of psychiatric case management, the consumer received the following services: SCIACCA Dual Diagnosis Assessment; Daily Living Activities assessment administered monthly; an Individualized Service Plan was developed in consultation with the client; weekly individual counseling sessions and referrals to other community resources as needed. The case manager also helped the consumer to apply for temporary financial assistance through the State’s general assistance fund and more permanent assistance through the Social Security supplemental insurance for those with disabilities.
Diagram 2
Each consumer participated in the following therapeutic group sessions: exercise groups; life skills training; anger management groups; health and nutrition training; a peer led group in support of those dually diagnosed with drug and alcohol addition; dual diagnosis education group; relapse prevention group; spiritual recovery group; community meeting and weekly worship services were available on and off campus. This holistic approach has enabled the staff to address most of the apparent needs of this targeted group. As we consider the case studies the questions that are to be considered are whether or not these efforts at intervening on behalf of the persons served were successful or not, what could have been done differently to insure an even greater level of success and what should be the additional actions taken?

CASE STUDIES

The following paragraphs represent the case studies of the ten men followed through the project.

(N. C.)

N.C. is a 55 year-old African-American male diagnosed with schizophrenia, paranoid type, and currently is experiencing homelessness. He presented himself for services at Odyssey III Safe-Haven in March of 2004. He had been released recently from incarceration and was residing in an Emergency Night Shelter.

N.C. came to Odyssey III after hearing about the program through a friend who was already in housing at Odyssey III-Safe Haven. The Grady Hospital staff officially referred him where he was in outpatient drug treatment (Grady Health System-Drug Dependency Unit). Previously, he had received medical treatment, secondary heart surgery (7/2003), and psychiatric treatment.
N.C. admits to a 20-year history of drug and alcohol abuse. His drug of choice was marijuana, but he has extensive histories of abusing cocaine, heroin and pain medications. "I used to take all that stuff, black beauties; amphetamines; you name it. In prison we used to trade and sell prescription meds too. I ended up addicted to Vicodin. Now I’m on methadone trying to keep from using any of that stuff.” Vicodin falls into the drug class of opiates—the same category as the heroin to which he was addicted.

N.C. was enrolled into the Odyssey III-Safe Haven on March 22, 2004. After beginning the necessary screening and admissions process, N.C. was initially denied admittance to the program. While he participated in the Grady Health System-System-Drug Dependency Unit methadone program, he required more support than available from this agency. Methadone is a substance that can have harmful and potentially fatal side effects on a consumer if it interacts with street drugs, alcohol, or unprescribed medications.

N.C. initially tested positive for opiate use due to his abuse of Vicodin. Odyssey III Safe-Haven consulted with N.C.’s clinical support team at the Grady Health Systems-Drug Dependency Unit. His case manager indicated that N.C. has a long history of abusing prescription medications, and that they too were quite concerned about his substance abuse.

After consulting with the Executive Director of Odyssey III Safe-Haven, the residential team decided that another urinalysis would be administered 30 days from the day he tested positive for opiates. He returned, passed the urinalysis and was admitted on a conditional basis. The 90-day conditional placement terms were:
1) N.C. would be given weekly tests for alcohol and illicit substances throughout his 90-day probationary period.

2) He would be required to attend support groups daily.

3) He is required to comply with all of his doctor’s clinical recommendations.

4) He is required to be in by 7:00 p.m. nightly.

5) He must take all medications as prescribed.

6) He must not keep any medications on his person.

After reviewing his prescriptions and attaining his medications from the pharmacy, he is required to turn in all medications and associated documentation to residential staff. All medications are kept in the staff office under lock and key.

N.C. agreed to the terms of his “conditional stay” and signed a copy of this written agreement. He was then matched with an appropriate roommate and assigned to a room.

N.C. seemed to adapt to the environment well and got along well with his roommate and other residents. He met with the residential team within his first month to discuss the goals that he has for himself while enrolled in the program. He then agreed to goal-related tasks that would be his responsibility.

From that point forward, N.C. met weekly to discuss his particular goals and progress on the goal-oriented tasks. The psychiatric case manager would also assist him in any necessary way (i.e. letters of referral; issuing tokens for transportation, etc.) so that he could accomplish his assigned tasks. The residential team facilitated therapeutic groups including: 1) Exercise group, 2) Life skills, 3) Anger management, 4) Health and
nutrition, 5) Peer Led Dual Diagnosis group, 6) Relapse prevention, 7) Spiritual Recovery, and 8) Community meeting.

N.C. struggled with feelings of paranoia due to his dual diagnosis of schizophrenia. In addition, N.C. has a long record of repeated incarcerations. He admits to a violent criminal history marked by drug offenses, armed robbery and shootouts with police. N.C., himself, was shot and often shared the story of this incident with other residents.

N.C. often recounted stories of incidents that occurred while he was incarcerated. In fact, he would often mistakenly refer to himself and other residents as “inmates”. His long prison sentences left him partially estranged from his family. His children, however, often visit. He has also been in frequent contact with his sister in Florida and has visited her for the holidays.

N.C. stated that he often attempted to share his experiences in an effort to assist the younger residents. He acknowledged a need for recovery in his life, not only from addiction and mental health issues, but also for the issues of homelessness and life as an ex-offender.

N.C. has demonstrated the capacity to address his Activities of Daily Living (i.e. health practices, behavior, personal hygiene, etc., at a reasonably functional level. His average score on the Daily Living Activities Scale (DLA) is 5.2 on a scale of 1-7, which would equal a Global Assessment of Functioning estimated score of 52.

N.C. has maintained his sobriety from alcohol and illicit street drugs, however, he has had two incidents of abusing prescribed medications since enrollment. Apparently, N.C. developed a relationship with three different pharmacists. He was connected to the
GHS-Pain Clinic subsequent to pain experienced from heart surgery. From this, he developed an addiction to his prescribed pain medication prior to enrollment at Odyssey III Safe-Haven. Additionally, he abused another medication while in-house by failing to disclose a prescription he had requested. He was connected to the Florida Hall pharmacy for psychiatric medications. He also received methadone at the pharmacy in the Grady Health System- (GHS)-Drug Dependency Unit (DDU).

N.C. demonstrated drug seeking behaviors by going to multiple physicians and, feigning pain, in order to obtain multiple prescriptions. He has been placed on In-House Probation twice since enrollment. He recently tested positive for Benzodiazepines at the Grady Health System- System-Drug Dependency Unit. At the request of N.C. Odyssey III staff administered an In-House test. He tested negative for all illicit substances. N.C. continues to deny abusing illicit substances and believes that officials at Grady Health System are attempting to sabotage him—a typical behavior for persons who experience paranoia.

Outcome

N.C. remains in the Odyssey III-Safe Haven program and has benefited from his enrollment in the following ways:

1) He is no longer homeless due to Safe Haven Transitional Housing.

2) N.C. has been out of prison, off parole and probation with no pending legal issues for 1 year and nine months. This is his longest term of continuous freedom from incarceration in his adult life.
3) N.C. has maintained abstinence from alcohol and street drugs. He has had fewer relapses to abusing prescription medications than at any other time in his adult life.

4) He has obtained interim financial assistance from State General Assistance, until his Social Security Disability case decision has been decided.

5) He has obtained Emergency EBT/Food Stamp benefits through the state.

6) He has applied for Disability benefits through the Social Security Administration.

7) He has reconnected with family members (sister, daughter and son).

8) He has experienced a decrease in psychiatric symptoms.

(J. H.)

J.H. is a 25 year-old African-American male who is diagnosed with schizoaffective disorder and currently experiencing homelessness. He came to the Odyssey III program on a referral from the Coweta County Jail and State of Georgia probation office. According to staff at the jail, J.H. was incarcerated due to an aggravated assault charge. He had allegedly become aggressive toward his family and the police were called to intervene. He had previously been hospitalized at Ridgeview Institute for a similar incident. J.H.’s father heard about the Odyssey III program and assisted in attaining the proper documentation so that he might be considered for placement. Coweta County Jail staff sent a letter stating that J.H. could be released from jail if he has a stable address. His parents and family had all previously indicated that he could not live with them. The jail forwarded all necessary psychiatric and PPD (tuberculosis test) information, J.H. was tentatively accepted. He was released from jail with the understanding that he must have negative urinalysis results and that he must be
approved for admission pending a face-to-face interview. J.H. came to Odyssey III on 10/15/04 for his final interview, urinalysis and admission. He tested negative for all substances tested but acknowledges a history of alcohol and marijuana use. His application was reviewed and discussed with him. He then read and signed an agreement to the rules of the program. (See attachment) He then was assigned to a room and the residential support staff reviewed his rights and responsibilities, took a statement of informal consent and reviewed the clients’ commitment to safety contract. J.H.’s application and other paperwork indicated that he was diagnosed with schizoaffective disorder. He presented with hostility and feelings of anger, particularly when discussing his father. He also experienced paranoia and felt that the Odyssey III staff conspired with his father to keep him in the Safe Haven program.

J.H. seemed to interact with his assigned roommate well, but would often be overheard yelling loudly to himself. When questioned about this pattern of behavior he often referred to negative feelings about his father.

J.H. appeared to have knowledge sufficient to adequately complete his Activities of Daily Life (ADLs) but his mental illness often distracted him from focusing on these issues.

He entered with a Daily Life Activities (DLA) score of 3.8. He has since remained at, generally, the same level of performance. His average Daily Life Activities (DLA) score is 3.4.

During his first month in housing, J.H. met with the residential team to complete his Individualized Service Plan (ISP). This document served as a written contract between J.H. and the staff and detailed what each party’s responsibilities were. All
subsequent individual and group sessions were related to goals in his ISP. J.H. regularly participated in the Odyssey III on-site therapeutic groups. These included: (1) Anger Management, (2) Peer Led Dual Diagnosis Group, (3) Relapse Prevention, (4) Spiritual Recovery, (5) Life Skills, (6) Dual Diagnosis Educational Group, and (7) Community Meeting.

J.H. often displayed disorganized thought and speech patterns and sometimes would speak on topics that were seemingly unrelated to the subjects being discussed. He would often read along with the group, but have a misunderstanding or misinterpretation of the meaning of words. He often found biblical literature especially difficult to interpret and took bizarre meanings from seemingly straightforward parables.

These issues were difficult to explore in group sessions because the group’s reality was totally different than J.H.’s reality. Individual sessions were better, but the level of disorganization often kept J.H. from grasping salient points. The residential support team communicated with J.H.’s psychiatrist and his psychiatrist suggested an increase in medication dosage. J.H. became agitated and refused to accept the medication increase. His behavior eventually became so unmanageable that he required hospitalization. J.H. went to the Psychiatric Emergency Unit at Grady Hospital, but adamantly refused to be admitted.

At that point the hospital changed his prescription to a previous set of medications because this is the only change that J.H. would accept. Due to the clients’ rights of self-determination, no medicines can be forced on a client unless he is a danger to himself or others.
J.H. remains in the Odyssey III-Safe Haven program and has shown some improvement in his mental status. He exhibits less agitation and appears to be more willing to accept his mental health issues. He has visited his family for the holidays without incident. “We straightened some things out,” stated J.H.

Outcome

Since entering the program, J.H. has:

1) Increased his knowledge of coping skills for his mental health and substance abuse issues.
2) Learned to utilize physical exercises as a means for releasing tension.
3) Connected with state EBT/Food Stamp benefits.
4) Improved relations with his father and siblings.
5) Met all requirements of State Probation.
6) Maintained sobriety.
7) Decreased in feelings of anger and agitation.

(D. F.)

D.F. is a 46 year-old African-American male diagnosed with schizoaffective disorder, depressed type. D.F. initially came to the Odyssey III Supportive service Center for assistance in April 2004. He was homeless at the time and usually slept at the Atlanta Union Mission Emergency Night Shelter.

D.F. entered the Odyssey III center and met with an intake specialist to complete the homeless verification process. (See appendix). He was then given an intake form to complete and ate a continental breakfast as he waited to be assigned to a counselor.
The assigned case manager conducted a needs assessment and discovered that he may meet the criteria for Odyssey III – Safe Haven Housing. He was given an application to be completed by his psychiatrist. In the meantime, he was allowed to participate in on-site therapeutic groups and to participate in the meal program.

Once D.F. returned with his completed application, he was scheduled for an interview with a psychiatric case manager. D.F.’s documentation indicated that he was diagnosed with a chronic and persistent mental illness that was likely to become disabling. He was judged to be an appropriate candidate for placement and referred for a PPD tuberculosis-screening test.

D.F. returned with negative PPD results indicating that he was not infected with contagious tuberculosis. He then met with the Director of Counseling who discussed his application with him and administered the pre-placement urinalysis. He tested negative for all illegal/illicit substances and was then enrolled into the program. Due to his illness, he often experienced auditory hallucinations that would regularly disturb his sleep. He acknowledge a pattern of awakening loudly from violent dreams and hearing disturbing “voices.” For this reason, he was assigned to a single room.

D.F. regularly participated in Odyssey III on-site therapeutic groups. This was done in conjunction with his assigned groups at Grady Hospital – Psychosocial Rehabilitation Day Program. The Odyssey III psychiatric case manager administered the Daily Living Activities Scale (DLA). His initial overall score was 4.6 on a scale of 1-7.

During his first month in housing, D.F. met with the residential team to complete his Individualized Service Plan (ISP). This document was the written agreement between D.F. and the residential team. All subsequent individual and group sessions were related
to the ISP. D.F. agreed to a set of goals and related objectives that he would address and
the team agreed to a set of related interventions that staff implemented.

The residential team would communicate with D.F.’s clinical treatment team
regularly to insure that his Odyssey III plan for residential support was in accordance
with his psychiatric treatment plan. This included a discussion of which groups D.F.
would attend at his Day Program and which ones he would participate in at Odyssey III.
The teams of support and D.F. decided that he would attend the following on site groups:
(1) Anger Management, (2) Exercise Group, (3) Peer Led Dual Diagnosis Support Group,
(4) Relapse Prevention, (5) Spiritual Recovery, (6) Life Skills, (7) Dual Diagnosis
Educational Group, and (8) Community Meeting.

He would also attend supportive groups at his Psychosocial Rehabilitation Day
Program whenever possible. D.F. also expressed a desire to work toward his Graduate
Equivalency Diploma (GED) and enrolled in a course.

D.F. continued to suffer with mental health issues including auditory/visual
hallucinations. He stated, “The voices won’t let me sleep. They keep tormenting me! The
only thing I know to do is to grab the closest weapon I can find and fight them!” At that
point D.F.’s room was searched to insure he had no actual weapons. A set of knives was
found and confiscated. D.F. was counseled on appropriate coping skills related to his
expressed feelings in the Dual Diagnosis Educational Group. His psychiatrist was
notified of his statements through a written letter that was given to his clinician on his
next mental health appointment.

D.F. frequently made comments in the groups about violence. “I just keep
hearing something telling me to hurt someone.” He often shared disturbing comments
related to hurting women. He also shared an instance from his past where the “voices” convinced him to buy a butcher knife and follow a woman home on the bus. However, he ran into a friend and the voices stopped before he hurt the woman.

These inappropriate thoughts and feelings were explored in both group and individual sessions. With D.F.’s written permission, Odyssey III staff would disclose his comments in group sessions to his psychiatrist.

This consumer has tried several different psychiatric medications since enrollment. His latest medication change appears to be quite beneficial as evidenced by decreased hallucinations, higher levels of functioning and an overall “happier” appearance (smiling/joking).

This is in sharp contrast to his initial paranoid and agitated appearance. D.F. remains in Safe Haven and is doing relatively well. His highest DLA score to date has been 5.65. His overall DLA average score since entering the program is 4.8.

**Outcome**

Since entering the program, D.F. has:

1. Increased his knowledge of coping skills for his mental health and substance abuse issues.
2. Improved his Life Skills (hygiene, shopping, cooking, *etc.*).
3. Obtained Financial Resources through the Social Security Administration.
4. Connected with a payee to assist him in meeting his financial responsibilities.
5. Reconnected with family members (brothers, sister, step father and aunt).
6. He has experienced a decrease in psychiatric symptoms.
7. Maintained Sobriety.
B.D. is a 50 year-old African-American male diagnosed with major depression disorder with psychotic features and Post Traumatic Stress Disorder. He also had bilateral partial hand amputations. B.D. came to Odyssey III for service in October of 2004. At the time he was homeless and living on the streets of Atlanta. He indicated that he had no friends or family in the area.

After presenting appropriate clinical information including a tuberculosis test, and a completed application, he was scheduled for an admission interview appointment. After passing the pre-placement urinalysis, he was paired with an appropriate roommate and assigned to a room.

B.D. was a very quiet and introverted person. He rarely expressed emotions and seemed to be withdrawn from others. He was encouraged, by the staff to participate more often in the group sessions. He eventually became more active and offered appropriate feedback in the sessions. He kept a recovery journal after being encouraged to do so by his psychiatric case manager.

B.D. met with the Safe Haven residential team within his first month in housing. He verbalized how he feels about several areas of his life and set some goals related to living independently. He agreed to a set of goal-related tasks that he would accomplish and the team agreed to the most appropriate interventions for his case. This plan would be reviewed every six months with the residential team to assess B.D.’s progress. Weekly, B.D. would meet with a psychiatric case manager who would document his progress toward completing his assigned tasks. This would be done in individual face-to-face sessions. Residential support staff (evening staff) would document interactions and
goal-related behaviors on a daily basis. B.D. also participated regularly in the on-site therapeutic groups including: (1) Anger Management, (2) Exercise group, (3) Peer Led Dual Diagnosis Support Group, (4) Relapse Prevention, (5) Spiritual Recovery, (6) Life Skills, (7) Dual Diagnosis Educational group, and (8) the regularly scheduled Community meeting.

B.D. met weekly with his case manager from the Grady Health System Mental Health Center – Hirsch Hall. He was served by outreach workers on the Community Outreach Services Program. B.D. was careful to make all psychiatric appointments and took medications as prescribed without fail. He would diligently get his prescription refilled prior to running completely out.

B.D. suffered with Post Traumatic Stress Disorder secondary to losing several fingers in an incident at work. B.D. stated, “I worked as a janitor at Georgia State. I was cleaning up in one of their laboratories and my hand started hurting. I took off my gloves and my fingers came off with them. I had apparently run across some type of chemical that had eaten my fingers off. I went to the hospital and these federal agents told me, ‘You ain’t gon’ get no money off of this. So just let it go!’ B.D. said that Georgia State often have foreign scientists doing experiments for biological warfare. He also said, “They told me that I couldn’t get workers’ compensation, and the next thing you know . . . I ended up in the Georgia Regional Psychiatric Hospital.”

B.D.’s story was typical of the type of assertions that are often made by psychotic clients. Whereas the events recounted could have occurred exactly as B.D. stated, there tends to be a trend of themes among those with paranoid delusions. Often the
government, CIA, or police are thought to be following or “out to get” the psychotic client.

Throughout the duration of his stay in the program, B.D. stuck to his story regarding what happened to his fingers. B.D. also admitted to history in the military and an “other than honorable” discharge due to a drug related offense. B.D., however, denied direct involvement.

B.D. was a model resident, group participant and team player with group activities. He often volunteered to serve breakfast in the meal program, pick up necessary donations, and maintenance duties.

B.D. went through the appropriate steps to apply for disability resources through the Social Security Administration and interim financial assistance through the State General Assistance Program. He eventually obtained disability benefits and relocated to his hometown in North Carolina.

B.D. received a lump sum of $13,000.00 from the Social Security Administration. He also receives $1,200.00 monthly in benefits. He planned to use the money to locate his estranged relatives. Against all advice from Odyssey III staff, B.D. left the program without a definite destination. He was given contact information to notify staff of his whereabouts, but he did not follow through with the phone call.

B.D. exited Safe Haven on 11/16/2005. His overall Daily Life Activities (DLA) average score since entering the program is 5.2. This score translates to an overall Global Assessment of Functioning score of 52.

Outcome

Since entering the program, B.D. has:
1. Increased his knowledge of coping skills for his mental health and substance abuse issues.

2. Improved his Life Skills (hygiene, shopping, cooking, etc.).

3. Obtained financial resources through the Social Security Administration.

4. Experienced a decrease in psychiatric symptoms.

5. Experienced the longest period of sobriety in his adult life, 10 months.

6. Made the choice to seek independent living in more familiar surroundings with family.

(W. L.)

W.L. is a 46 year-old African-American male diagnosed with schizoaffective disorder, diabetes, arthritis, and morbid obesity. He is also currently experiencing homelessness. He had been recently brought to Atlanta by his family after they became aware of his location. W.L. had been homeless for over 15 years on the streets of California.

W.L. has a prior history of attaining a bachelor degree in journalism and working as a journalist for several reputable newspapers. He disclosed that his mother had mental health issues and that his father was an alcoholic and abusive. He believes that he became mentally ill as a result of a “coven of devil worshippers and witches.” He believes that he was branded on the forehead with a pentagram, which he believes is a sign of Satan. He believes that Satan worshippers across the United States communicate with each other in a conspiracy to harm him. He joined the Catholic Church because, “I heard that they really know how to handle those demonic spirits.” This paranoid delusion
is typical of those who suffer with his particular mental disorder. These delusions are accentuated by auditory, visual, and tactile hallucinations.

"Last night I saw a big guy dressed in all black with a machine gun and a sword telling me that the U.S. had better get out of Iraq," stated W.L. He made this statement during his Individualized Service Plan consultation. He also stated, "The other day, when I was in group, I saw a beer can with arms and legs dancing and singing while flying in the air."

Due to his extensive history of sleeping on the street, W.L. acknowledged being unable to sleep throughout the night. "You get used to the sounds and the feel of the wind. Plus between certain hours of the night, you're more likely to get robbed or hurt, so I trained myself to be awake during those hours." It was this sleeping pattern that initially disturbed W.L.'s relatives who initially took him in and tried to integrate him into the family.

"He would get up and go outside at 2:00 or 3:00 in the morning. The alarm would beep and he would disturb everyone's sleep, stated W.L.'s brother-in-law. This brother-in-law is a member and deacon at the Chapel of Christian Love Baptist Church—the sponsor of Odyssey III-Safe Have. He initially referred the client to the program.

W.L. regularly participated in Odyssey III on-site therapeutic groups. These included: (1) Anger Management, (2) Exercise group, (3) Peer Led Dual Diagnosis Support group, (4) Relapse Prevention, (5) Spiritual Recovery, (6) Life Skills, (7) Dual Diagnosis Educational group, and (8) Community meeting.

W.L. was referred to Grady Hospital to obtain psychiatric and medical care in Atlanta. He brought records of his previous medical and psychiatric care with him from
California and he was given appropriate medications for his physical and mental illnesses.

W.L. presented documentation of mental and physical health status and this information was incorporated into his Individual Service Plan. After agreeing to goal-related tasks that he would complete and interventions to be completed by the residential team, W.L. met weekly with a psychiatric case manager to follow-up on agreed upon goals.

W.L. has a pattern of non-compliance with taking medications properly, therefore, he had to be monitored closely to insure he took medications. He often complained of nausea and diarrhea that he believes was caused by his medications. W.L. is also diabetic and his food intake has to be monitored closely.

W.L. remains in Odyssey III- Safe Haven and his overall DLA average score since entering the program is 4.0 or a score of 40 on the Global Assessment Functioning Scale.

Outcome

Since entering the program, W.L. has:

1. Increased his knowledge of coping skills for his mental health and substance abuse issues.
2. Obtained appropriate medical and psychiatric treatment.
3. Improved his Life Skills (hygiene, shopping, cooking, etc.).
4. Obtained interim financial assistance through the State General Assistance.
5. Obtained EBT Food Stamp benefits.
6. Experienced a decrease in psychiatric symptoms.
7. Maintained sobriety.

8. Improved family relationships by visiting with family for holidays.

(M. S.)

M.S. is a 26 year-old African-American male who was diagnosed with schizophrenia, paranoid type and cannabis dependency. He was referred to Odyssey III-Safe Haven in January 2004 by the Fulton County Jail- Mental Health Court staff. Prior to incarceration, M.S. had lived with his grandmother in public housing. Due to an allegation of sexual misconduct with a young child, he is banned from returning to the apartment complex. Therefore, he is homeless. The Mental Health Court would only release this client, if he had a suitable address for discharge. Jail staff requested that Odyssey III send a worker to interview M.S. for appropriateness. After gathering all of his necessary paperwork to insure that he met admission criteria, Odyssey III-Safe Haven staff went to the Fulton County Jail to meet with M.S. At this meeting, M.S. appeared to be appropriate for placement, although he was younger than most residents who enter Odyssey III. “When can I get out?” was the first question that he asked.

M.S. was transported to Odyssey III by jail staff on January 22, 2004. Rather than completing the admission process, he left. Staff had been in contact with his grandmother previously and she called to report his location. Additionally, she brought M.S. personally to Odyssey III-Safe Haven on January 23, 2004 for admission. He was administered a pre-placement drug and TB screening, signed off on agreeing to the rules and was matched with an appropriate roommate.
M.S. had a history of repeated incarceration due to substance abuse and mental illness that his cousin would use his identification when he was arrested, and that several of the charges that appear on his record were actually caused by his cousin.

M.S. received services at West Fulton Mental Health Center prior to his last incarceration. He was referred, consequently, to this agency for psychiatric support. He complied with this request and meets with his clinician once per month. He has been prescribed several different combinations of medicines since enrollment. His non-compliance with medications eventually required his clinician to place him on a regiment of monthly injections.

M.S. suffers from paranoia, depression, and delusional thinking. “I used to think I was Jesus. Now I think I am Mark Anthony, who was married to Cleopatra.” He would also hallucinate visually and auditorily. “I hear music coming from my heart. I feel like it’s my theme music,” he said. He also felt that there was someone sitting up in the tower above Grady Hospital that controls his thoughts. M.S. often stated, “I saw this whole place in a vision before I came here. I saw all the staff and everything. That’s why when I came here . . . I couldn’t believe it.”

M.S. met with the residential team and vocalized some goals that he would like to accomplish while at Odyssey III-Safe Haven. These goals were related to maintaining his sobriety, mental stability, attaining financial benefits, improving life skills and finding permanent housing. He agreed to a number of goal-related tasks that he would complete and the team agreed to a set of supportive interventions.

Weekly he would meet with a psychiatric case manager at Odyssey III to follow-up on these identified goals. He would also attend on-site therapeutic support groups

He eventually connected with a supportive, off-campus day program at Community Friendship Incorporated. Here, he would explore options for Vocational Rehabilitation. M.S.’s enrollment in this program was short lived, as he quickly lost interest and stopped attending the program. His sporadic attendance came to the attention of staff, and he admitted that he had been going to visit his new girlfriend instead of attending the program. He soon afterwards tested positive for marijuana and was placed on In-House Probation. His probation required daily volunteerism in the Odyssey III kitchen, reduced curfew hours, restriction from off-campus activities, restriction from family visits, increased drug screening, and mandatory enrollment in a Substance Abuse Program.

M.S. remains in the Odyssey III- Safe Haven Program and remains on In-house Probation. He has tested positive for illicit substances three times while enrolled at Odyssey III – Safe Haven. His overall Daily Life Activities (DLA) average score since entering the program is 4.6. This translates to a Global Assessment of Functioning score of 46.

Outcome

Since he entered the program, M.S. has:

1) Increased his knowledge of coping skills for his mental health and substance abuse issues.

2) Improved Life Skills (hygiene, shopping, cooking, etc).
3) Obtained interim financial resources through the State General Assistance Program.

4) Obtained EBT/Food Stamp benefits through the state.

5) Improved family relationships including frequency of family contacts and family visits.

6) Experienced a decrease in psychiatric symptoms.

**(D. B.)**

D.B. is a 50 year-old African-American male diagnosed with major depressive disorder with psychotic features. He had previously been a resident of Odyssey III-Safe Haven and was discharged to a permanent housing placement at O’Hearn House in Atlanta. This client returned to Odyssey III-Safe Haven after being evicted from this placement due to a violent altercation with another resident.

Odyssey III-Safe Haven has a policy that states: each candidate for housing must have at least six months of time lapse since their last aggressive, combative incident. His placement, therefore, would have to be discussed with the entire residential support team, and staff from O’Hearn House. D.B. had previously been a model resident and completed the program on his last admission without incident. D.B. signed a release of information so the resident team could speak with O’Hearn House about the incident. All information gathered indicated that D.B. was not the aggressor in this incident.

The residential team gave a recommendation of placing D.B. on a probationary basis with the understanding that “any” rule violation or indications of violent behavior or intentions would result in immediate termination from housing. The Director of
Counseling and the Executive Director of Odyssey III-Safe Haven gave final approval to this plan.

D.B. was required to submit updated psychiatric information and current PPD results. All documentation indicated he was appropriate for placement. D.B. was then accepted into the program and assigned to a room with an appropriately matched roommate. D.B. met with the residential team to complete his Individualized Service Plan (ISP) within his first 30 days in housing. He agreed on a list of goals, tasks, and objectives that all related to his maintenance of stability. He acknowledged that since he last left the program, he had not taken his medications correctly. He also relapsed and began using drugs and alcohol while living at his last placement. D.B. stated, “I’ve learned that in order for me to make it . . . I have to have structure. The place where I was living was okay, but it did not provide enough structure for me.”

D.B. met with his assigned case manager weekly to follow-up on his agreed goals. He was a diligent participant in group meetings and appeared to be committed to the meetings and activities that supported his recovery. His initial score on the Daily Living Activities (DLA) scale was 5. He also scored an overall average score of 5. This would indicate a Global Assessment of Functioning (GAF) score of 50.

D.B. regularly met with his clinical treatment team at Grady Hospital. Odyssey III-Safe Haven staff remained in contact with them through a written letter that he would take to his Mental Health (MH) appointments. They would, with permission from the client, fax or send a reply including any new diagnoses, medications, etc.

D.B. applied for disability benefits through the Social Security Administration and was eventually approved. D.B.’s time in the program was marked by a strong desire
to find a more permanent housing placement (i.e., a privately, leased apartment). “It has been so long since I had my own place. I just want to be able to take a bath,” stated D.B.

D.B. was reminded by Odyssey III staff that he must make the necessary life changes so that he may remain sober after discharge. Whereas the team acknowledged D.B.’s participation in groups and awareness of recovery literature, we also reminded him of his last relapse and the associated factors. The team reminded him of his initial statement, “I’ve learned that in order for me to make it . . . I have to have structure.”

Despite the advice of the residential team and other members of his supportive network, D.B. left the program the day after he received his first Social Security check. The residential team was concerned on the day he received his check because D.B. stopped the postman to get his check on the street before the mail made it to the mailroom. D.B. had been adamantly opposed to the Odyssey III policy, which states that all residents who receive Social Security benefits must work with a payee to assist them in managing their finances. D.B. got his check without notifying staff, left campus without notice and paid the required move-in fees for his new apartment. He returned to campus after hours stating he had found an apartment. On the next morning D.B. met with staff for his Exit Interview and turned in his key.

**Outcome**

Since D.B.’s readmission to the program he has:

1.) Increased his knowledge of coping skills for his mental health and substance abuse issues.

2.) Maintained sobriety for 6 months.

3.) Obtained financial resources through the Social Security Administration.
4.) Improved his Life Skills (hygiene, shopping, cooking, etc.).
5.) Reconnected to psychiatric and medical treatment.
6.) Experienced a decrease in psychiatric symptoms.
7.) Improved Anger Management skills during his last stay at Odyssey III-Safe Haven and he has refrained from any aggressive, combative behavior.
8.) Obtained a permanent housing placement that is affordable to him.

(V. D.)

V.D. is a 53 year-old African-American male diagnosed with schizophrenia, paranoid type, and currently is experiencing homelessness. He had previously completed the Odyssey III-Safe Haven program, and had moved into a more permanent housing placement with his family. Apparently, this arrangement worked for several months. However, V.D.’s family member with whom he was living became financially challenged and was unable to pay his portion of the rent. V.D., consequently, spent several months living in hotels and rooming houses. During this time he became disconnected from his psychiatric care and his mental health began to deteriorate. As a result, he began sleeping at Emergency Night Shelters throughout downtown Atlanta.

V.D. returned to Odyssey III-Safe Haven Supportive Services with his brother in August 2005. His brother approached staff and asked if V.D. could return to transitional housing in Odyssey III-Safe Haven. By this time V.D. was virtually unable to communicate his needs due to the disorganized thoughts, delusions and hallucinations that accompany his diagnosis of schizophrenia.

V.D. was required to first re-establish his psychiatric care, and was referred to the Grady Health System. After getting psychiatric medications and returning with an
updated dual diagnosis and negative PPD results, he was approved for re-admission to housing.

V.D. had always been a relatively easy-going resident and was easily placed with an appropriate roommate. V.D. was administered a pre-placement drug screening test that was negative for all substances tested.

V.D. regularly participated in Odyssey III on-site therapeutic groups. He would often make comments that were seemingly unrelated to the topic being discussed. He often spoke of a person named, “Alabama” who would tell him different information about people around him. Over the next few weeks, V.D. began to talk less about his hallucinations and his comments in the group and individual sessions would become more appropriate. Once he became relatively mentally stable, he was scheduled for his Individualized Service Plan (ISP) to set goals for the time he would spend at Odyssey III-Safe Haven.

V.D. set goals related to maintaining abstinence from drugs and alcohol; maintaining mental stability; budgeting his disability resources; improving knowledge of life skills and improving family relationships. V.D. became more focused and exhibited a more organized thought process in observed interactions. He also became more withdrawn, however, and remained quiet throughout most group sessions unless asked a direct question. Although this pattern is in sharp contrast to his recent behavior, i.e., this present admission, he was typically withdrawn, isolative, and quiet during his first admission. V.D. did not speak openly about his psychiatric symptoms unless he was asked a direct question. He would indicate an understanding of the topics presented through appropriate feedback in group exercises. He regularly attended his monthly
appointments with his psychiatrist. Odyssey III staff, with permission from the client, communicated with his clinical team through written letters taken by V.D. to his monthly appointments. These forms also had space for the clinician to write down necessary information and changes to his case to be sent back to Odyssey III.

V.D. seemed to stabilize at his baseline level of functioning rather rapidly after he re-connected with his case manager. His psychiatrist prescribed the same medications that had stabilized him previously. V.D. acknowledges drinking alcohol while he was living on the streets. He participated in all on-site groups including: (1) Anger Management, (2) Exercise group, (3) Peer led dual diagnosis support group, (4) Relapse Prevention, (5) Spiritual recovery, (6) Life Skills, (7) Dual Diagnosis Education Group, and (8) Community meeting.

V.D. remains in Safe Haven and is doing well. His overall Daily Life Activities (DLA) average score since readmission to the program is 4.2. This translates to a Global Assessment of Functioning score of 42.

**Outcome**

Since entering the program, V.D. has

1. Increased his knowledge of coping skills for mental health and substance abuse issues.
2. Re-connected to psychiatric care.
3. Abstained from using alcohol or street drugs.
4. Experienced a decrease in psychiatric symptoms.
5. Reconnected with family and visited family for the holidays.
(6) Reconnected with Disability benefits through Social Security Administration.

(7) Improved Life Skills (hygiene, shopping, cooking, etc.).

(H. S.)

H.S. is a 26 year-old African-American male diagnosed with schizophrenia, paranoid type. He was currently experiencing homelessness and presented for services at Odyssey III in March 2005. He has been homeless for five years and he attributes this to mental health symptoms. He has had several hospitalizations due to psychiatric problems and has also completed a substance abuse treatment program in the past (2004).

H.S. completed an initial needs assessment and presented documentation from Georgia Regional Psychiatric Hospital related to his illness. He was referred to the psychiatric case manager at Grady Hospital. He had a previous history of non-compliance with his psychiatric medications, and, therefore, is in need of psychiatric education and close medication monitoring. H.S. presented negative PPD results and tested negative for all illicit substances. He was eventually regarded as appropriate for placement and enrolled on March 10, 2005. H.S. was matched with an appropriate roommate and assigned to a room.

During his first month in housing, H.S. met with the residential team to complete his Individualized Service Plan. He agreed to a set of goals and goal-related tasks that he would complete during his time at the Safe Haven. In turn, the residential team agreed to a set of interventions that they would initiate. It was determined that H.S.’s need of psychiatric education was in part because of the recent onset of his illness. He needs to learn about his illness and develop necessary coping skills. He would attend all onsite groups including (1) Anger Management, (2) Exercise Group, (3) Peer Led Dual
Diagnosis support group, (4) Relapse Prevention, (5) Spiritual Recovery, (6) Life Skills, (7) Dual Diagnosis Educational group, and (8) Community meeting.

H.S. often expressed his feelings about his mental illness in these group settings.

“I tried to tell my family about my mental illness and they didn’t understand. My mother and sister are real religious and they say I should bind that spirit in the name of Jesus!”

H.S. exhibited delusional thoughts and stated, “I believe that I am a king in heaven. I saw it in a vision just like the people in the bible. I saw my face in the clouds and heard a voice saying everything will be okay.” H.S. also shared, “I thought everyone could hear the voices. I thought they were just pretending like they couldn’t hear them so I would think I was crazy! Now I know that I’m on a mission from God. All schizophrenics are special to God because we see visions and hear his voice.”

H.S. seemed to place particular emphasis on the Spiritual Recovery Group.

“Reverend Jackson brings up some good points. I think that I have something special to tell people from God.” H.S. did not have a history of aggression or violence, and a limited substance abuse history. He did acknowledge, however, a history of marijuana use. “I used to think that the weed was good because it made me hear the voices. That’s when they were telling me positive stuff. But then they started telling me negative stuff. They would talk about me and call me a punk!”

H.S. reflected on his time as homeless, unmedicated, and smoking marijuana. “I was out of control. I would hear the voices talking about me, and I thought everyone else could too. So I would yell back at them. . . I would curse at them and tell them I wasn’t no punk. Other people on the street would get mad because they thought I was talking to them. That’s when I was out of my mind.”
This client has been prescribed several different medications since enrollment. He appears to be functioning well and has enrolled in the State Vocational Rehabilitation Program. He is currently studying to become a barber. "The medications have helped a lot, but the groups help even more. The groups teach you how to understand and control the illness, so it helps me do better in school."

H.S. remains in Safe Haven and has relapsed into substance abuse. His overall DLA average score since entering the program is 4.5. H.S. stated, "When I smoke weed I can hear the voice of God clearer." This writer pointed out the consequences of his actions. After his drug use, consumer's thought pattern was increasingly disorganized, as evidenced by inappropriate comments and bizarre behavior.

Outcome

Since entering the program, H.S. has:

1. Increased his knowledge of coping skills for his mental health and substance abuse issues.
2. Improved Life Skills (hygiene, shopping, budgeting, cooking, etc.).
3. Obtained interim financial assistance through the State General Assistance Program.
4. Reconnected with family members and visiting them during holidays.
5. Experienced a decrease in psychiatric symptoms.
7. Enrolled in vocational education course.
(R. P.)

R.P. is a 49 year-old African-American male diagnosed with schizophrenia, paranoid type, and currently experiencing homelessness. He became homeless due to incarceration. He had previously received Social Security Disability benefits, but the benefits were discontinued upon incarceration.

R. P. previously was a resident at Safe Haven and is on his second admission. He was previously terminated due to rule violations. He left the program without notice after relapsing on drugs and alcohol. He recently received Social Security benefits and admittedly solicited a prostitute and used cocaine with her. He also stole the microwave from the kitchen in the Safe Haven building. He had been restricted from re-entering the program due to these circumstances. The Executive Director of Odyssey III- Safe Haven approved his returning to this placement on the recommendation of his clinician at Grady Health Center. “Mr. P is a totally different person since his last incarceration. He has been doing really well.”

R.P. was required to present his current diagnostic information, list of medication and updated PPD results. All documentation indicated that he was an appropriate candidate for placement. R.P. was accepted back into program and paired with an appropriate roommate.

R.P. completed his Individual Service Plan (ISP) within his first month in housing. This is where he had the opportunity to share his goals with the residential team. The group then specified which goal-related tasks would be required of R. P., and which interventions would be required of the residential team. This process utilized a client-centered approach from ones’ strengths perspective. The strengths perspective
focuses goals around the client’s “strengths and abilities” as opposed to focusing on “problems.” All participants sign the plan to document their agreement to adhere to these steps.

Weekly, R.P. would meet with his psychiatric case manager to follow-up on identified goals. He also attended therapeutic support groups on-site, including: 1) Exercise group, 2) Life skills, 3) Anger management, 4) Health & Nutrition, 5) Peer led Dual Diagnosis group, 6) Dual Diagnosis Educational group, 7) Relapse Prevention, 8) Spiritual Recovery, 9) and Community meeting.

R.P.’s initial average score on the Daily Living Activities (DLA) scale was 3.45. His overall average up to this point is 3.9, which indicates an estimated Global Assessment of Functioning score of 39. He has benefited from the Life Skills sessions on hygiene and admits to a previous history of not showering regularly. R.P. attributes this to depression.

This consumer takes medication orally and injections. He has stated that his doctor is considering changing his medications because they have potential of harming his liver. R.P. already has a damaged liver due to Hepatitis C. He does feel, however, that his current medications address his psychiatric condition adequately. “I’ve been on Haldol since I was in prison,” stated R.P.

R.P. has participated consistently in the Odyssey III Breakfast Program, but has shied away from cooking. “I want to improve my cooking skills. I used to be a dishwasher when I was working, but I didn’t ever cook.” The Life Skills are assisting him in developing those necessary skills.
Outcome

1) Unfortunately, R.P. has recently relapsed to drugs and alcohol use. "I ran across a female I use to kick it with. I tricked off with her and used alcohol, marijuana, and cocaine." He was placed on In-House Probation and daily work detail; in order to insure that he has continuous contact with support from staff.

2) Increased his knowledge of coping skills for his mental health and substance abuse issues.

3) Improved his ability to perform necessary Life Skills (hygiene, shopping, cooking, household cleaning, etc.).

4) Maintained Transitional Housing placement.

5) Experienced a decrease in psychiatric symptoms.

6) Obtained EBT/Food Stamp assistance.

SUMMARY

The interventions and subsequent placements appear to have been appropriate for the most part. Success can be measured by the fact that these men were no longer homeless as a result of their placements in this program. In the case of consumer N.C., he also experienced his longest term of continuous freedom from incarceration in his adult life. These men were able to maintain abstinence from illegal drugs and alcohol with a minimal amount of relapse. In many cases the consumer was reconnected with family members, some had been estranged for many years. All of those in the program experienced a decrease in psychiatric symptoms, became stabilized through the regular monitoring of their medications. These persons increased their knowledge of coping
skills for their mental health and substance abuse issues. They also learned to utilize physical exercise as a means for releasing tension and anxiety. Some of the men were on probation from incarceration in state prison; there were none to be re-arrested for violation of probation rules. This was encouraging because it represents a break in the cycle of incarceration release and subsequent re-incarceration.

Considering the above stated results, I can conclude that the intervention on behalf of the men in this study was successful. Could we improve in our efforts? Of course we could and one these improvements would be to involve more of the church members and perhaps family members of the people served. They could volunteer to accompany the consumer to appointments such as those with doctors, therapists, the social security office and others. This would help the consumer stay focused and not fall prey to others who know them from the streets. Some have been attacked and robbed of their monies after receiving their monthly benefit check. Others have been persuaded to use drugs and alcohol again and there are always the voices that are so prevalent with those diagnosed as bipolar or schizophrenic. It was discovered that the consumers could benefit greatly by having someone to help them manage their monies. A policy was established that all residents must have a payee. That person would be someone certified to assist the mentally challenged with their budget and disbursements of funds as well as insuring their needs were met financially.

We also discovered that it was not safe for those being discharged to leave with large sums of cash. Many would have several thousands of dollars after receiving their first social security check. A policy was made that those monies would be dispersed in a cashier’s check or personal money order.
CHAPTER IV
EVALUATION AND CONCLUSION

CLIENTS

Evaluation of the ministry project occurred on a number of levels. First, was the evaluation of the impact of the program on the individual men who participated in the program. Much of that evaluation was indicated in the previous chapter in connection with the individuals who served as our case study group. At this point, what is called—for is a global evaluation of the project as a whole.

At the outset, we can say that the interventions and subsequent placements appear to have been appropriate for clients at Odyssey III—Safe Haven for the most part. Success can be measured by the fact that these men are no longer homeless as a result of their placement in this program. In the case of one of the participants, he experienced the longest term of continuous freedom from incarceration in his adult life. The men were able to maintain abstinence from illegal drugs and alcohol with a minimal amount of relapse. In many cases, the client was reconnected with family members. Some of these had been estranged from family members for many years. All of those in the program experienced a decrease in psychiatric symptoms and became stabilized through the regular monitoring of their medications. These persons increased their knowledge of coping skills for their mental health and substance abuse issues. They also learned to utilize physical exercise as a means for releasing tension and anxiety. Some of the men were on probation from incarceration in state prisons. None were re-arrested for violation
of probation rules. This was encouraging because it represents a break in the cycle of incarceration, release, and subsequent re-incarceration. Considering these results, one must conclude that the program was and is a successful program for a highly at-risk population.

We have also found that success in the project has been strongly influenced by our efforts in the area of spiritual recovery. For us the term spiritual recovery is used to emphasize the importance of a transcendent, divine awareness in one’s life for recovery to occur. As asked earlier, “Is there anything that God cannot do?”

It was explained to individuals in the group and the group at large that, spiritually, all persons are in recovery from something—whether it is a behavioral pattern that has been proven to be detrimental or a habit that has caused one to suffer negative effects. At Odyssey III-Safe Haven, we seek to alter those behaviors and break negative habits. The other side of this equation, however, is the complicating issue of the patients’ mental illness. We seek to show God’s love and comfort for all who are ill and recognize that we are not ministering simply to persons with a “deficiency of will—power,” or, merely, volitionally antisocial. Both of these issues must be kept continually in mind for the success of a program of this type.

When the project began, the Spiritual Recovery component of the program was facilitated by one of the leadership staff at the Chapel of Christian Love Baptist Church. Initially, the clients appeared to be distrustful of the clergy or any other person they were meeting for the first time. They were suspicious that persons unknown to them were potentially dangerous and would try to harm them. They wanted to know if the leadership person was indeed a “real” preacher or not. When assured that, in fact, the
leadership person was indeed an ordained minister of the gospel, they wanted to know “Why then are you here with folk like us”? We were challenged by our ministry paradigm transformation to explain to clients that real ministers belonged with folk just like them.

The challenge, foremost, was to establish mutual trust and assure clients of the desire to help them understand and experience God’s presence in their lives in the midst of their circumstances. They were encouraged to believe that they could and would get better as they placed their faith in God to help them understand and manage their illness. For some, this resulted not only in spiritual recovery but also spiritual discovery. Whether relief was sought through medication for mental illness or abstinence from drugs and alcohol, we found there was a grave need on the part of the client for a solid spiritual foundation. It is clear that, when a spiritual component is a significant part of the program, the likelihood for success on the part of the client is greatly increased.

Clients, therefore, are instructed in scriptures and methods of daily devotions. Their testimony is that their daily prayer life had been of the greatest benefit in their improving wellness. Prior to establishing this practice, clients would often awaken to a new day with fear and anxiety as they considered trying to make it through another day. When their day began with prayer, they felt a strong sense of confidence to face whatever the day would bring. What we have found in this undertaking is that prayer and devotion does in fact change people, circumstances and lives. Could we improve in our efforts to relate to the individual clients? Of course we could and we are actively engaged in this on-going reflection among the leadership and the volunteer staff.
One of the improvements we are considering is to involve more of our church members, and, perhaps, family members of the people served. They could volunteer to accompany the clients to appointments with doctors, therapists, the social security office and other service agencies. This would help the client to stay focused and not fall prey to those who know them from the streets in their dysfunctionality. Some have been attacked and robbed of their monies after receiving their monthly social security check. Others have been persuaded to use drugs and alcohol again, and, there is always the voices that are so prevalent with those diagnosed as bipolar or schizophrenic. We discovered that the clients would benefit greatly by having someone to help them manage their monies. As such, a policy was established that all residents must have a “payee.” That person would be someone certified to assist the mentally challenged with their budget and disperse funds, as well as, insuring their financial needs were met. In this regard, a policy was made that monies distributed to clients would be dispersed in a cashier's check or personal money order for their safety and security.

PERSONNEL AND ADMITTANCE

When the personnel structure was reviewed and evaluated, it was discovered that the program was initially understaffed and under-funded. The assumption was made that if there was sufficient staffing during the day, the evening staff could be shared with a second dormitory that housed another population of previously homeless men. On that basis, only the after mid-night security guard would be needed, since it was assumed that the men would be asleep.

We discovered, however, that when people are medicated with psychotropic medications they have different sleeping patterns and they may not be stabilized to the
point that they are able to sleep all night. As a result, residential staff needed to be on
duty throughout the night until the day shift returned. It was determined, therefore, that
volunteers were needed and could be utilized to a greater degree to meet this
responsibility.

Evaluation of admittance policies demonstrated, after several negative
experiences, a number of inappropriate placements were made. Some were inappropriate
because the illness of the client caused them to be combative and violent. Others, on the
other hand, were too sick physically to participate in the program and, the program was
not designed to treat severe cases of diabetes, hypertension and constant seizures. As a
result, we developed a referral system to personal care homes, nursing homes and
rehabilitation centers for clients that were inappropriate for the program.

Having underestimated the staffing, we also found that we underestimated the
amount of monies needed for a program of this scope. The start-up money was provided
by the U.S. Department of Housing and Urban Development but after the first few
months it became clear that the one hundred fifty—thousand dollar annual budget would
fall far short of the real need. Appeals were made to the Federal Emergency
Management Agency, the State Department of Community Affairs and the local
governments for more assistance. It became clear that more than three hundred thousand
dollars were needed to operate the program successfully.

The additional monies were found through a substance abuse and mental health
fund that the Federal Government disperses through the State Department of Human
Resources. As a result, there is now a sufficient amount of money to provide adequate
staffing and programming for treatment and care for homeless men with chronic mental health issues in this program.

CONCLUSION

In conclusion, the contributions that were made by addressing this ministry issue are many. Among those, we found that one must be intentional as to the population that one seeks to serve. Here, demographics are extremely important. One cannot develop programs where vast differences exist in the population that is to be served when these differences are between male, female, elderly and young. Programs must be demographically specific.

We also found that among the persons experiencing homelessness, at least thirty percent, of these suffer from some aspect of mental illness. It is further believed that most of these persons are also addicted to drugs, alcohol or both. The establishment of a Safe Haven for those diagnosed with chronic mental illness and those dually diagnosed with chronic mental illness and addiction issues is paramount for their recovery and re-integration into society and for society at large. The program, therefore, includes access to a psychiatrist with regularly scheduled visits, a psychotherapist who is on site when possible, case managers and other support staff to support the clients stabilization, health, healing and recovery. Ultimately, the client, if we together are successful, will be able to move on to a more independent living situation either in a group home, independent living with support services or, more importantly, to their own private living quarters.

Families, we discovered, have been frustrated, as well, by the unavailability of residential services for their family member that is homeless due to crises experienced as a result of mental illness. Now, families are served by having a safe place for their
family members to reside, be monitored and counseled through their crises. Once the persons are stabilized, and, given assistance in understanding their illness, they are more prepared to re-enter a supportive or independent living situation.

The community is served also by having a place designated for persons to reside other than under expressway overpasses, bridges, or in abandoned automobiles, alley-ways and doorways of commercial buildings. Further, the community would be served by a reduction in arrests of these persons and the cost of multi-week incarcerations, the frequent visits to local emergency clinics, and other agencies related to providing social and health service to this population which is homeless and not properly medicated.

The local church benefits too by having a designated place providing it with the opportunity to serve this underserved segment of our population through its various ministries. We have earlier noted that having a “place of residence” is essential to the stabilization and therapeutic process. The program as undertaken could not have achieved success through the use of our traditional church facilities.

The church universal is served by having a model project of ministering to persons who are homeless and diagnosed with a chronic mental illness. What we have demonstrated is that the program at the Chapel of Love Baptist Church could be replicated by any church, synagogue, mosque or faith-based organization. In the judgment of this author, any group of believers, regardless of its size, or denominational affiliation, or even its budget, can do what the Chapel of Christian Love Baptist Church has done. This faith community simply read the gospels and believed that Jesus’ ministry of proclaiming the coming of the Kingdom of Heaven and ministering healing to the sick could be implemented by any group through discipleship.
At the outset of this program, we as a faith-community had no idea of the legal requirements of acquiring a federal designation of a non-profit organization as described by a 501 (c)(3) designation. None of us had ever written a proposal or applied for a grant, yet we sought out classes that were offered on the subject and began to make inquiries.

It must be noted, however, that we did not wait until monies were found before actions were taken. The Chapel of Christian Love Baptist Church had been feeding homeless persons for over five years before ever seeking any support beyond that which the local church could provide. We discovered, however, that funding agents do not fund good ideas, rather, they fund people who are busy doing something; people who have a record of service to others and the community in which they live and worship. It is our conviction, therefore, that if the Chapel of Christian Love Baptist Church could undertake a task of this magnitude, when it was only ten years into its existence, having no monies, and less than a hundred active members, any church, mosque or synagogue can do even greater works. It simply requires faith in God, others and yourselves.
APPENDIX 1

CRITERIA FOR ODYSSEY III – SAFE HAVEN

1. Resident must have a documented mental illness. Referring agency/case manager should verify documentation; prior-to-referral-to-Odyssey III – Safe Haven.
2. Resident must be homeless. This should also be documented by referring agency/case manager prior to referral.
3. Resident must be determined able to live semi – independently. This includes:
   a. Client must be ambulatory.
   b. Resident should be able to bathe, clean and care for their personal area. Residents will be held responsible for the maintenance of their room and common areas (including kitchen and bathrooms).
   c. Residents will rotate and perform necessary maintenance tasks as deemed necessary.
   d. Resident should be able to prepare light meals – use microwave; making sandwiches.
4. Resident must be able to live comfortably in a group residence. Although our facilities have private and semi – private accommodations, the resident must be able to interact with other residents and staff without aggression or combative behavior.
5. There should be no recent history of aggression or combative behavior. (Including arrests for violent acts, or any threatening behavior).
6. We do not require participation in services and referrals as a condition of occupancy. However, residents should be able to participate in general campus activities. Residents will be given an option as to whether they would like to be involved in either:
   a. A therapeutic day program
   b. Volunteerism in various capacities around the Odyssey III campus
   c. Any viable, productive activity as agreed upon by Resident and Odyssey III Social worker.
7. We encourage each resident to get involved in some type of productive activity. Resident and case manager will determine a reasonable daily schedule for each resident.
8. Social Worker and resident will continuously work towards the resident moving into more traditional forms of housing. Resident should understand this as a goal upon entering the program.
9. Final decision on accepting a resident into Odyssey III – Safe Haven is made by the Odyssey III – Social Worker as approved by the Executive Director.
10. Each resident must sign a Release of Information form. Odyssey III – Social Worker will gather information to verify applicable documentation.
11. Each resident is required to have 30 days of sobriety prior to admission. A pre-placement drug test will be administered.
12. A TB test is required prior to admission. Client must present documentation of a negative screening.
13. Odyssey III Transitional Housing will assess a $30 program fee for clients with income. Clients without income will be admitted and their program fee will be subsidized.
(Revised 12/2000)
APPENDIX 2

ODYSSEY III – SAFE HAVEN TRANSITIONAL HOUSING

RULES AND REGULATIONS

1. Drugs and alcohol will not be tolerated or allowed. Violations of this rule will result in dismissal from the program. Smoking is also prohibited inside of Safe Haven units; all smoking is to be limited to outside of building.

2. No fighting. All parties involved may be dismissed from the program.

3. No stealing or borrowing from the other residents without their permission. Any stealing may result in dismissal from the program.

4. Each Odyssey III – Safe Haven Housing resident is expected to meet with Odyssey III staff to create an Individual Service Plan. At this time, client and staff will set goals and objectives to be accomplished during your stay at Odyssey III.

5. Each resident is required to be involved in a constructive regimen of daily activities. Client will meet with program staff to create a schedule that is most appropriate and beneficial for each resident.

6. If you are recovering from substance abuse, you will be individually assessed and may be placed on conditional stay. This conditional stay will be based on your individual agreement with Housing Staff. Staff will work with client to explore appropriate options for support around this issue.

7. Chores will be assigned and posted. You are responsible for the chore assigned to you. Inspections will be conducted and you will be required to complete your chore on a daily basis.

8. House Meetings are mandatory. You are required to attend. Each resident is expected to attend all House Meetings unless there is a medical appointment or another legitimate and verifiable excuse.

9. Life Management Skills workshops are mandatory. Each resident is expected to attend unless there is a medical appointment or another legitimate and verifiable excuse.
10. Residents will meet with Odyssey III staff to reassess their Individual Service Plan weekly.

11. Resident is required to meet with staff to discuss a financial stabilization plan within 30 days of move in date. If you have a payee, you are required to disclose the payee’s name and contact information upon acceptance into Transitional Housing.

12. The curfew for Odyssey III – Safe Haven is 9:00 pm on weeknights and 10:30 pm on the weekend. Violations of curfew may result in dismissal from program.

13. No personal visitors are allowed in the Transitional Housing program at any time. The privacy of others should be considered and respected at all times.

14. You are to sign in and out whenever you leave the premises. A sign in/out sheet will be provided for you. This is for your protection.

15. You may use this address for mailing purposes. Mail distribution hours are Monday – Friday from 1 pm to 3:30 pm.

16. You have access to the PCCI Permanent Housing Coordinator who can assist you with permanent housing placement. You are expected to participate in a housing assessment process within the first month of your stay. Permanent Housing Coordinator and Odyssey III Safe Haven staff will coordinate this assessment meeting.

17. Odyssey III Executive Director must give final approval to each resident. Each resident has the right to meet with Odyssey III Safe Haven staff and/or Odyssey III Executive Director regarding said decision.

I have heard and/or read the Rules and Regulations of Odyssey III Safe Haven Housing. I understand the requirements for continued stay. I understand that I am expected to work toward a goal of Permanent Housing and that Odyssey III staff will assist in this process. I understand that violation of these rules may result in dismissal from the program.

My signature on this document is a testament that I agree to govern myself by the Rules and Regulations as outlined above.

Resident Signature: ___________________________ Print Name ___________________________

Housing Staff: ___________________________ Print Name: ___________________________

Date: ___________________________
APPENDIX 3

CLIENT RIGHTS

1. Each Odyssey III-Safe Haven client has the right to live in a safe environment. Odyssey III will provide clinical support and security personnel to insure the safety of the campus.

2. Each Odyssey III-Safe Haven resident has the right to address questions/concerns regarding policy in an organized forum. All residents will participate in a Community Meeting. This meeting will be held on a weekly basis, every Friday, at 2:30pm. At this time residents will be given the opportunity to address concerns with staff and fellow residents.

3. Residents have the right to enter and exit the campus at will between the hours of 6am and 9pm (curfew time – 10:30pm on weekends).

4. Residents have the right to withdraw their program enrollment at any time.

5. Residents have the right to file a grievance with the Executive Director if they feel that staff has not adequately addressed their needs.

6. Residents have the right to file a grievance with the DHR-Metro Regional Office should they feel the Executive Director has not adequately met their needs.

CLIENT RESPONSIBILITIES

1. Residents are required to follow all program rules.

2. Residents are required to participate in a constructive daily regiment of activity. This may include community mental health day programs; volunteer activities; educational enrichment; vocational rehabilitation; or any other viable, constructive activity as agreed upon by staff and resident.

3. Residents are responsible for keeping themselves and their personal living space clean.

4. Residents are responsible for signing the program roster on a daily basis.

5. Residents are responsible for signing the sign in/sign out log whenever leaving Odyssey III Campus.

6. Each resident is required to follow all recommendations of their primary mental health professional (i.e. taking all prescribed meds; complying mental health appointments, etc.)

7. Each resident is required to meet with staff to create an Individualized Service Plan and an Individualized Crisis Plan.

8. Each resident is required to work toward a goal of Permanent Housing.
I have heard and/or read the rights and responsibilities of all residents of Odyssey III-Safe Haven. My signature below indicates my understanding and willingness to comply with program expectation.

Resident

Odyssey III Staff
APPENDIX 4

SAFE HAVEN BREAKFAST PROGRAM
WEEKLY TIME CARD/RATING SHEET

Name: ____________________________________________

For the week of ________________ thru ____________

<table>
<thead>
<tr>
<th>DAYS</th>
<th>IN</th>
<th>OUT</th>
<th>DUTIES</th>
<th>STAFF INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MONDAY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TUESDAY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WEDNESDAY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>THURSDAY</td>
<td></td>
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<tr>
<td>FRIDAY</td>
<td></td>
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</tr>
</tbody>
</table>

PERFORMANCE: (EACH ITEM IS WORTH 10 POINTS)

<table>
<thead>
<tr>
<th>PERFORMANCE MEASURES</th>
<th>POINTS GIVEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consumers took meds and completed chore prior to reporting for duty.</td>
<td></td>
</tr>
<tr>
<td>2. Consumer took a shower, brushed teeth and had on cleaning clothing.</td>
<td></td>
</tr>
<tr>
<td>3. Consumer was on time and prepared for duty.</td>
<td></td>
</tr>
<tr>
<td>4. Consumer washed hands upon entering the kitchen.</td>
<td></td>
</tr>
<tr>
<td>5. Consumer wore gloves when preparing and serving food.</td>
<td></td>
</tr>
</tbody>
</table>

109
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Consumer prepared food or participated in cooking training.</td>
</tr>
<tr>
<td>7.</td>
<td>Consumer communicated well with team members.</td>
</tr>
<tr>
<td>8.</td>
<td>Consumer was open to constructive feedback.</td>
</tr>
<tr>
<td>9.</td>
<td>Consumer treated customers with respect.</td>
</tr>
<tr>
<td>10.</td>
<td>Consumer remained in kitchen until clean up was complete.</td>
</tr>
</tbody>
</table>

TOTAL POINTS Earned: __________

Signature/Title of Staff Rater: __________________________
APPENDIX 5

Global Assessment of
Relational Functioning (GARF) Scale

Instructions: The GARF Scale can be used to indicate an overall judgment of the functioning of a family or other ongoing relationship on a hypothetical continuum ranging from competent, optimal relational functioning to a disrupted, dysfunctional relationship. It is analogous to Axis V (Global Assessment of Functioning Scale) provided for individuals in DSM-IV. The GARF Scale permits the clinician to rate the degree to which a family or other ongoing relational unit meets the affective or instrumental needs of its members in the following areas:

A. Problem solving – skills in negotiating goals, rules, and routines; adaptability to stress; communication skills; ability to resolve conflict
B. Organization – maintenance of interpersonal roles and subsystem boundaries; hierarchical functioning; coalitions and distribution of power, control, and responsibility
C. Emotional climate – tone and range of feelings; quality of caring, empathy, involvement, and attachment/commitment; sharing of values; mutual affective responsiveness, respect, and regard; quality of sexual functioning

In most instances, the GARF Scale should be used to rate functioning during the current period, (i.e., the level of relational functioning at the time of the evaluation). In some settings, the GARF Scale may also be used to rate functioning for other time periods (i.e., the highest level of relational functioning for at least a few months during the past year).

Note: Use specific, intermediate codes when possible, for example, 45, 68, 72. If detailed information is not adequate to make specific ratings, use midpoints of the five ranges, that is, 90, 70, 50, 30, or 10.

81-100 Overall: Relational unit is functioning satisfactorily from self-report of participant from perspectives of observers.
Agreed-on patterns or routines exist that help meet the usual needs of each family/couple member; there is flexibility for change in response to unusual demands or events; and occasional conflicts and stressful transitions are resolved through problem-solving communication and negotiation.
There is a shared understanding and agreement about roles and appropriate tasks, decision making is established for each functional area, and there is recognition of the
unique characteristics and merit of each subsystem (e.g., parents/spouses, siblings, and individuals).

There is a situationally appropriate, optimistic atmosphere in the family; a wide range of feelings is freely expressed and managed within the family; and there is a general atmosphere of warmth, caring, and sharing of values among all family members. Sexual relations of adult members are satisfactory.

**61-80 Overall:** Functioning of relational unit is somewhat unsatisfactory. Over a period of time, many but not all difficulties are resolved without complaints.

Daily routines are present, but there is some pain and difficulty in responding to the unusual. Some conflicts remain unresolved but do not disrupt family functioning.

Decision making is usually competent, but efforts at control of one another quite often are greater than necessary or are ineffective. Individuals and relationships are clearly demarcated but sometimes a specific subsystem is depreciated or scapegoated.

A range of feeling is expressed, but instances of emotional blocking or tension are evident. Warmth and caring are present but are marred by a family member’s irritability and frustrations. Sexual activity of adult members may be reduced or problematic.

**41-60 Overall:** Relational unit has occasional times of satisfying and competent functioning together, but clearly dysfunctional, unsatisfying relationships tend to predominate.

Communication is frequently inhibited by unresolved conflicts that often interfere with daily routines; there is significant difficulty in adapting to family stress and transitional change.

Decision making is only intermittently competent and effective; either excessive rigidity or significant lack of structure is evident at these times. Individual needs are quite often submerged by a partner or coalition.

Pain or ineffective anger or emotional deadness interferes with family enjoyment. Although there is some warmth and support for members, it is usually unequally distributed. Troublesome sexual difficulties between adults are often present.

**21-40 Overall:** Relational unit is obviously and seriously dysfunctional; forms and time periods of satisfactory relating are rare.

Family/couple routines do not meet the needs of members; they are grimly adhered to or blithely ignored. Life cycle changes, such as departures or entries into the relational unit, generate painful conflict and obviously frustrating failures of problem solving.

Decision making is tyrannical or quite ineffective. The unique characteristics of individuals are unappreciated or ignored by either rigid or confusingly fluid coalitions.

There are infrequent periods of enjoyment of life together; frequent distancing or open hostility reflect significant conflicts that remain unresolved and quite painful. Sexual dysfunction among adult members is commonplace.
1-20 Overall: Relational unit has become too dysfunctional to retain continuity of contact and attachment.

Family/couple routines are negligible (i.e., no mealtime, sleeping, or waking schedule); family members often do not know where others are or when they will be in or out; there is a little effective communication among family members.
APPENDIX 6

Instruction: Use the scale below to rate how often or how well each of the 20 activities of daily living were performed or managed independently during the last 30 days. Enter N/A is the activity was not assessed due to inadequate information.

<table>
<thead>
<tr>
<th>ne of the time; reme severely impairment or problems functioning; vasive level of continuous paid supports needed</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A little of the time; severe impairment or problems in functioning; extensive level of continuous paid supports needed</td>
<td>Occasionally; moderately severe impairment or problems in functioning; low level of continuous paid supports needed.</td>
<td>Some of the time; moderate impairment or problems in functioning; low level of continuous paid supports needed.</td>
<td>A good bit of the time; mild impairment or problems in functioning; moderate level of intermittent paid supports needed.</td>
<td>Most of the time; very mild impairment or problems in functioning; low level of intermittent paid supports needed.</td>
<td>All of the time; no significant impairment or problems in functioning requiring paid supports</td>
<td></td>
</tr>
</tbody>
</table>

DAILY ACTIVITIES

<table>
<thead>
<tr>
<th>Activity</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 10th Practices</td>
<td>Takes care of health issues, infections; takes medication as prescribed; follows-up on medical appointments.</td>
</tr>
<tr>
<td>2. Using</td>
<td>Maintains stable housing; organizes possessions, cleans.</td>
</tr>
<tr>
<td>3. Mmunication</td>
<td>Listens to people; expresses opinions/feelings; makes wishes known effectively.</td>
</tr>
<tr>
<td>4. Daisy</td>
<td>Safely uses small appliances, ovens/burners, matches, knives, razors, other tools; safely moves about community.</td>
</tr>
<tr>
<td>5. Naging Time</td>
<td>Follows regularly schedule for bedtime, wake-up, meal times, rarely tardy or absent for work, day programs, appointments, scheduled activities.</td>
</tr>
<tr>
<td>6. Naging Money</td>
<td>Manages money wisely, controls spending habits.</td>
</tr>
<tr>
<td>7. Ritions</td>
<td>Eats at least 2 basically nutritious meals daily.</td>
</tr>
<tr>
<td>8. Bllem Solving</td>
<td>Resolves basic problems of daily living, asks questions for clarity and setting expectations.</td>
</tr>
<tr>
<td>9. Daily onships</td>
<td>Gets along with family, positive relationships as parent, sibling, child, significant other family member.</td>
</tr>
<tr>
<td>10. Alcohol/Drug</td>
<td>Avoids abuse or abstains from alcohol/drugs; understands signs and symptoms of abuse or dependency; avoids misuse or combining alcohol, drugs, medication.</td>
</tr>
<tr>
<td>11. Pussion</td>
<td>Relaxes with a variety of activities; attends/participates in sports or performing arts events; reads newspapers, magazines, books; recreational games with others; involved in arts/crafts; goes to movies.</td>
</tr>
<tr>
<td>12. Community</td>
<td>Uses other community services, self-help groups, telephone, public transportation, religious organizations, shopping.</td>
</tr>
<tr>
<td>13. Social Network</td>
<td>Gets along with friends, neighbors, coworkers, other peers.</td>
</tr>
<tr>
<td>14. Actuality</td>
<td>Appropriate behavior toward others; comfortable with gender, respects privacy and rights of others, practices safe sex or abstains.</td>
</tr>
<tr>
<td>15. Productivity</td>
<td>Independently working, volunteering, homemaking, or learning skills for financial self-support.</td>
</tr>
<tr>
<td>16. Singing Skills</td>
<td>Knows about nature of disability/illness, probable limitations, and symptoms of relapse; behaviors that cause relapse or make situation/condition worse; options for coping, improving, preventing relapse, restoring feelings of self-worth, competence, being in control.</td>
</tr>
<tr>
<td>17. Behavior Norms</td>
<td>Complies with community norms, probation/parole, court requirements, if applicable; controls dangerous, violent, aggressive, bizarre, or nuisance behaviors; respects rights of others.</td>
</tr>
<tr>
<td>18. Personal Hygiene</td>
<td>Cares for personal cleanliness, such as bathing, brushing teeth.</td>
</tr>
<tr>
<td>19. Rooming</td>
<td>Cares for hair, hands, general appearance; shaves</td>
</tr>
<tr>
<td>20. Dressing</td>
<td>Dresses self; wears clean clothes that are appropriate for weather, job, and other activities; clothing is generally neat and intact.</td>
</tr>
</tbody>
</table>

Total Score: 114
<table>
<thead>
<tr>
<th>PERMES</th>
<th>Consumer Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgia's Performance Measurement and Evaluation System</td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health DAILY LIVING ACTIVITIES (DLA) PILOT STUDY</td>
<td>CID</td>
</tr>
</tbody>
</table>