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P R E F A C E

Helen was referred to the Thresholds (Chicago) Mobile Assessment Unit (MAU) by a local shelter. Shelter staff described her as "depressed, refusing to change her clothes, and flat." Helen had been staying at the shelter for four months and described herself as homeless for the last three years. Though guarded, Helen revealed that she had experienced audio hallucinations since age eight, had prior substance abuse treatment, had never received mental health treatment, and had a history of physical abuse as evidenced by a large scar on her face.

Helen didn't want mental health services, but she did want her own place to live and a copy of her birth certificate. She accepted a bed in the Thresholds Safe Haven, a low-demand supportive residential program housed in the local YMCA. She got her birth certificate and continued to work with MAU staff on basic living skills such as shopping, hygiene, and food preparation. She also began seeing a psychiatrist at a mental health clinic located in the YMCA. Unfortunately, Helen stopped taking her medication and was hospitalized during a psychiatric crisis.

When she returned to the Safe Haven, Helen made some different choices. She stopped drinking alcohol, stayed on her medication, and began to attend housing and social meetings held at Safe Haven. Over the next year, she began receiving disability benefits and started working with a Thresholds Assertive Community Treatment (ACT) team. She joined outings to the Museum of Modern Art and attended a microwave cooking class.

The day came when Helen wanted to move to a large studio apartment in a Thresholds group home. She said she was ready to "cook her own meals again" and "get some space." Staff and other members celebrated with her at her graduation party. In the 15 months the MAU, Safe Haven, and ACT staff worked with Helen, they came to view the scar on her face as both a reflection of her many internal scars and as a testament to her endurance. On graduation day, all you could see was her smile.

More than a decade after the Federal Task Force on Homelessness and Severe Mental Illness called it "unacceptable" for people with serious mental illnesses to live in unsafe and threatening conditions, more than 630,000 individuals are homeless in this country on any given night (Burt et al., 2001). About half of all adults who are homeless have substance use disorders, and many have co-occurring mental illnesses, as well. Yet, the outlook is far from bleak. Federal demonstration programs and the experience of hundreds of community-based providers offer a rich reservoir of evidence-based and promising practices.

For example, recent studies reveal that the cost of providing permanent, supportive housing for people with serious mental illnesses is more than offset by savings incurred by the public hospital, prison, and shelter systems (Culhane et al., 2001). When nothing is done, people with serious mental illnesses and/or co-occurring substance use disorders who are homeless often cycle between the streets, jails, and high-cost care, including emergency rooms and psychiatric hospitals. This is inhumane, ineffective, and costly.

Further, research reveals that people with serious mental illnesses and/or co-occurring substance use disorders who are homeless, once believed to be unreachable and difficult-to-serve, *can* be engaged into services, *can* accept and benefit from mental health services and substance abuse treatment, and *can* remain in stable housing with appropriate supports (Lam and Rosenheck, 1999; Morse, 1999; Lipton et al., 2000; Rosenheck et al., 1998). Clearly, *the time has come to end homelessness among people with serious mental illnesses and/or co-occurring substance use disorders.* We know what works. Now we must put what we know to work.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Mental Health Services, in collaboration with SAMHSA's Center for Substance Abuse Treatment (CSAT), have developed this *Blueprint for Change* to disseminate state-of-the-art information about ending homelessness for people who have serious mental illnesses, including those with co-occurring substance use disorders. This edition of the *Blueprint* does not fully consider the growing knowledge base that addresses homelessness among people with substance use disorders who do not have a serious mental illness. A future edition will cover this in greater depth. This document is more than a review of current and past research. It offers practical advice for how to plan, organize, and sustain a comprehensive, integrated system of care designed to end homelessness for people with serious mental illnesses and/or co-occurring substance use disorders.

This effort comes at a time of increased national attention to the needs of our most vulnerable citizens. SAMHSA has received increased funding to help end homelessness among people with mental illnesses and substance use disorders, and recently submitted a report to Congress on the prevention and treatment of co-occurring disorders. SAMHSA also is participating in an interagency effort among the Departments of Health and Human Services (HHS) (SAMHSA's parent agency), Housing and Urban Development (HUD), and Veterans Affairs (VA). These Departments have joined in an historic collaboration to provide $35 million for the development of appropriate housing and supportive services for people who are chronically homeless, and together are sponsoring a series of policy academies for state and local policymakers to improve access to mainstream resources for this population.

It is important that efforts to end homelessness address the substance use treatment needs of the population, given that recent estimates that nearly half of persons who are homeless have substance use disorders (Culhane, 2001). The Administration has expressed its commitment to reduce drug use, build treatment capacity, and increase access to services that promote recovery from substance use. It has pledged $1.6 billion over the next 5 years to do so. SAMHSA is not alone in these efforts. Across the country, states and communities are unveiling their own comprehensive plans to end homelessness. These plans focus on increased affordable housing opportunities, improved housing and service coordination, and better partnerships with mainstream systems and providers. Efforts to end homelessness can be modeled and supported at the Federal and state levels, but the real work takes place in the communities where people live.

The human and financial toll of homelessness for people with serious mental illnesses and/or co-occurring substance use disorders is incalculable. Equipped with cost-effective solutions that work and the will to implement them, states, communities, and providers can begin the difficult but necessary work of systems change to the benefit of persons with serious mental illnesses and co-occurring substance use disorders. This *Blueprint* provides the knowledge and the strategies to do so.

More detailed information on the research and practices featured in this report can be found in the References (beginning on page 101); many citations include web sites that contain documents or additional information. In addition, the Resources section includes contact information for some additional Federal, state, and national resources on homelessness, mental illnesses, and co-occurring substance use disorders. While inclusion on the resources list does not imply endorsement by SAMHSA or HHS, readers are encouraged to contact these organizations for more information or for technical assistance on specific topics. Additional information on homelessness and mental illnesses and substance use disorders is available on the SAMHSA web site at www.samhsa.gov.

U S I N G   T H I S   R E P O R T

*This **Blueprint for Change** is divided into eight chapters that comprise four sections: Before You Begin, Plan for Services, Organize Services, and Sustain Services. These sections reflect four action steps that states and communities can take to prevent or end homelessness among people with serious mental illnesses, including those with co-occurring substance use disorders (also referred to in this text as people with serious mental illnesses or co-occurring disorders). Each chapter presents current knowledge and specific strategies designed to carry out the action steps (see graphic, page xiv). A brief description of the contents of each chapter follows.*

C H A P T E R ■

1   Understand the Changing Context of Care and the Nation's Response.

This chapter outlines the current state of community-based treatment for people with serious mental illnesses and/or co-occurring substance use disorders. It also highlights the Federal response to homelessness for this vulnerable group.

C H A P T E R ■

2   Learn About the Population.

This chapter examines the characteristics of people with serious mental illnesses and/or co-occurring substance use disorders who become homeless, and the barriers they face to regaining mental and residential stability and sobriety.

C H A P T E R ■

3   Establish Core Values.

This chapter highlights the concept and practice of recovery and outlines a set of both person-centered and system-level values that must be the foundation for service delivery and systems change.

C H A P T E R ▪

4   Establish a Comprehensive, Integrated System of Care.

This chapter provides a set of principles and mechanisms designed to help build coalitions, integrate services, and effect systems change.

C H A P T E R ▪

5   Finance a Comprehensive System of Care.

This chapter provides an overview of funding sources for housing and supportive services, and principles to access and use these resources in the community.

C H A P T E R ▪

6   Use Evidence-Based and Promising Practices.

This chapter highlights a set of evidence-based and promising practices that respond to the housing, treatment, and support service needs of people with serious mental illnesses and/or co-occurring substance use disorders who are homeless.

C H A P T E R ▪

7   Measure Results.

This chapter examines the need to ensure accountability in an integrated system of care by demonstrating measurable results and performing ongoing monitoring and quality assurance.

C H A P T E R ▪

8   Use Mainstream Resources to Serve People Who Are Homeless.

This chapter highlights the range of mainstream resources available to people who are homeless and ways to make mainstream programs both accessible and accountable to them.

**Using this Report to Plan, Organize, and Sustain Services for
People with Serious Mental illnesses or Co-occurring Disorders Who Are Homeless**

CHAPTER	KEY LESSONS
Section I. BEFORE YOU BEGIN	
1. Understand the Changing Context of Care and the Nation's Response	■ Understand how treatment for serious mental illnesses and substance use disorders has evolved ■ Study the Nation's response
2. Learn About the Population	■ Recognize individual risk factors ■ Explore service system challenges ■ Learn about societal risk factors
3. Establish Core Values	■ Understand the concept and practice of recovery ■ Support values that put people first ■ Create a system that supports recovery
Section II. PLAN FOR SERVICES	
4. Establish a Comprehensive, Integrated System of Care	■ Develop the infrastructure for systems change ■ Engage in strategic planning ■ Participate in community-wide planning ■ Streamline existing funding
5. Finance a Comprehensive System of Care	■ Secure additional resources ■ Leverage new funds
Section III. ORGANIZE SERVICES	
6. Use Evidence-Based and Promising Practices	■ Adopt or adapt evidence-based practices ■ Offer a comprehensive set of essential services ■ Make use of Federal resources, including toolkits, TIPS,[1] and CAG[2] and TCE[3] grants
Section IV. SUSTAIN SERVICES	
7. Measure Results	■ Measure client-level outcomes ■ Measure system-level outcomes ■ Use management information systems
8. Use Mainstream Resources to Serve People Who Are Homeless	■ Use mainstream resources to prevent homelessness ■ Improve access to mainstream programs ■ Expand the capacity of mainstream programs ■ Promote coordination and collaboration ■ Build the infrastructure of housing and services ■ Create public awareness

[1]Treatment Improvement Protocols

[2]Community Action Grant

[3]Targeted Capacity Expansion

BEFORE YOU BEGIN

Strategies to prevent and end homelessness among people with serious mental

illnesses or co-occurring disorders must be based on a strong foundation of

knowledge about who these individuals are, why they are susceptible to

homelessness, and what has been done to learn more about their characteristics

and service needs. Much of what we know attests to both the extreme vulnerability

and the remarkable resilience of this disadvantaged and disenfranchised group.

We also know that people with serious mental illnesses and/or co-occurring

substance use disorders who are homeless can and do recover.

The first three chapters in this report—Understand the Changing Context of Care
and the Nation's Response, Learn About the Population, and Establish Core
Values—provide a basic understanding of individuals with serious mental illnesses
or co-occurring disorders who are homeless, and establish a set of values that
underlie all work on their behalf. In these chapters, you will learn about the need
to:

- Understand how treatment for serious mental illnesses and substance use
  disorders has evolved;
- Study the Nation's response;
- Recognize individual risk factors;
- Explore service system challenges;
- Learn about societal risk factors;
- Understand the concept and practice of recovery;
- Support values that put people first; and
- Create a system that supports recovery.

Additional information about the materials cited in these chapters can be found in
the References. Organizations that offer technical assistance in these areas are
listed in the Resources section.

C H A P T E R

■ 1

Understand the Changing Context of Care and the Nation's Response

Homelessness has become an enduring presence in American society. Despite

two decades of Federal support, statewide planning, and local initiatives, an

estimated 637,000 adults in the United States are homeless in a given week,

with 2.1 million adults experiencing homelessness over the course of a year

(Burt et al., 2001).

The estimated 200,000 people who experience chronic homelessness tend to have disabling health and behavioral health problems.

Most studies show that the majority of people who become homeless are without a place to live for only a short period of time. They usually become homeless as a result of an unexpected event such as an eviction, natural disaster, or house fire, and tend to have more social and economic resources to draw on than those who remain homeless for longer periods of time.

A much smaller group of homeless people either is episodically homeless (i.e., have many episodes of homelessness but each for short periods of time) or is chronically homeless (i.e., have few episodes of homelessness but each for long periods of time). One study of shelter users in two large cities found that 80 percent were temporarily homeless, 10 percent were episodically homeless, and 10 percent were chronically homeless (Kuhn and Culhane, 1998).

The estimated 200,000 people who experience chronic homelessness tend to have disabling health and behavioral health problems. Recent estimates suggest that at least 40 percent have substance use disorders, 25 percent have some form of physical disability or disabling health condition, and 20 percent have serious mental illnesses (Culhane, 2001). Often individuals have more than one of these conditions. These factors contribute not only to a person's risk for becoming homeless but also to the difficulty he or she experiences in overcoming it. People who experience chronic homelessness also tend to be slightly older than those who experience shorter homeless episodes, are non-white, and male (Culhane and Kuhn, 1998). Families and youth experience chronic homelessness, as well.

Without assistance, people with serious mental illnesses were among the first to be displaced when urban neighborhoods and single-room-occupancy hotels were gentrified in the 1980s.

Serious Mental Illnesses

Gone are the days when people with serious mental illnesses spent most of their lives in large, impersonal state institutions. The locus of care for people with serious mental illnesses has shifted over the past 30 years from the state hospital to the community. The number of patients in state psychiatric hospitals dropped from 560,000 people in 1955 to 77,000 people in 1996 (Bachrach, 1996).

Much of the decrease in the state hospital census can be attributed to deinstitutionalization, which sought, in part, to address well-publicized abuses in state hospitals by shifting treatment to the least restrictive setting for people with serious mental illnesses. Deinstitutionalization was abetted by the introduction in the 1950s of antipsychotic medication and by the creation of the Medicaid and Supplemental Security Income (SSI) programs in the 1960s that provided financial incentives for community care.

However, the realities faced by people with serious mental illnesses in their communities were in stark contrast to the promise of deinstitutionalization. The Community Mental Health Centers (CMHC) Act of 1963 was designed to address the needs of people with mental illnesses in their communities, but the vast array of needed services and supports never materialized.

In particular, fewer CMHCs than anticipated were created, and those established offered primarily clinic-based services that frequently were inaccessible or inappropriate for individuals with the most serious disorders. As a result, many individuals leaving institutions never connected with community-based mental health services. Others cycled in and out of jails and prisons. Without assistance, people with serious mental illnesses were among the first to be displaced when urban neighborhoods and single-room-occupancy hotels were gentrified in the 1980s.

By the late 1970s, the Community Support Program (CSP), now administered by SAMHSA's Center for Mental Health Services (CMHS), was adopted as the framework for developing a comprehensive range of services that would allow people with serious mental illnesses to live successfully outside of institutions. Some of the elements of the CSP approach included: outreach, income and medical assistance benefits, 24-hour crisis assistance, psychosocial rehabilitation, employment services, long-term supportive services, medical and mental health treatment, family support, residential services, case management, rights protection, and advocacy. Today, these elements remain as the cornerstone of comprehensive, community-based systems of care for people with serious mental illnesses.

Some communities have programs specifically designed to serve people with serious mental illnesses who are homeless. These programs include emergency shelters, outreach programs, drop-in centers, transitional housing, and health

care. Outreach programs have been effective in reaching people with serious mental illnesses who are homeless, especially those who are unable or unwilling to accept help from more traditional office-based providers. In many cases, these efforts are literally saving people's lives.

While, certainly, success stories exist, the numbers of people in need far exceed the capacity of programs that provide the intensive outreach and case management services required. Many people with serious mental illnesses receive fragmented and uncoordinated treatment, housing, and support services, if they receive them at all. They may cycle in and out of hospitals, jails, shelters, and life on the streets at enormous cost to both themselves and their communities.

Substance Use Disorders

In the not so distant past, "public inebriates" typically were sent to the drunk tanks of local jails to dry out. In 1956, the American Medical Association declared alcoholism a disease, lending support for medical treatment instead of incarceration. The 1971 Uniform Alcoholism and Intoxication Treatment Act, also known as the Hughes Act, officially decriminalized public drunkenness and mandated a medical treatment approach.

Instead of being jailed, homeless people who were alcoholics were sent to publicly funded detoxification programs where they could receive some form of treatment (Stark, 1987). However, studies of detoxification programs for indigent people reveal that few individuals leave with referrals for treatment, and the majority of those who are given referrals do not use them. These results led the researchers to conclude that the [Hughes] Act had replaced the revolving jail door with a "padded revolving door" (Sadd and Young, 1987).

Though medical treatment is still a mainstay for individuals with substance use disorders, this approach has its drawbacks for people who are homeless. Treatment is expensive, residential stays are short (often, no more than 28 days), and, without adequate discharge planning, individuals frequently return to the streets (McMurray-Avila, 2001). People with substance use disorders in day treatment programs may have no place to sleep at night. The combination of poverty and addiction are significant barriers to adequate housing, an issue that will be explored further in Chapter 2.

In the 1970s, the social model emerged in California as an alternative treatment approach for alcoholism and other substance use disorders. Social model programs are peer-oriented rather than professionally led and focus on the need for behavior change through experiential learning and shared responsibility (McMurray-Avila, 2001).

One study that assessed the effectiveness of social-setting detoxification for homeless individuals with severe alcohol dependence found that this approach was as safe and effective as hospital detoxification (Haigh and Hibbert, 1990; Zerger, 2002). Because social model programs are less costly than medical

treatment, they primarily serve indigent individuals. However, they struggle to secure funding from public agencies, and their services are rarely deemed reimbursable by third-party insurers (Zerger, 2002).

Many individuals who are homeless have both substance use disorders and serious mental illnesses. A growing body of research supports the concept of integrated treatment for these individuals; that is, treatment for both disorders provided concurrently by the same clinician or team of clinicians in a single setting (Drake et al., 1998). Such treatment is particularly beneficial in helping individuals recover from substance use (Oakley and Dennis, 1996). However, few such programs exist. The significant unmet need for both mental health and substance abuse treatment means that those with the fewest resources are least likely to receive appropriate care.

T H E   F E D E R A L   R E S P O N S E

Ending chronic homelessness among people with serious mental illnesses and/or co-occurring substance use disorders is an achievable goal. The Stewart B. McKinney Homeless Assistance Act of 1987 (P.L. 100-77)—known today as the McKinney-Vento Act—was the first and, to date, the only comprehensive Federal legislation to address homelessness. The Act included a number of provisions designed specifically to provide health and mental health care to people with serious mental illnesses and substance use disorders who are homeless.

Amendments to the McKinney Act—made in 1988, 1990, 1992, and 1994—for the most part, have strengthened the provisions and expanded the scope of the original legislation (National Coalition for the Homeless, 1999). Since enactment of the McKinney Act, the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services, and the U.S. Department of Housing and Urban Development, have funded innovative housing and service programs, and research and demonstration projects to determine how best to serve people with serious mental illnesses and substance use disorders who are homeless. These programs served as a catalyst for further development of the evidence-based practices presented in this report.

A Framework for Services

The McKinney Act also established the Interagency Council on the Homeless (now the Interagency Council on Homelessness) to provide Federal leadership for activities to help homeless individuals and families. Comprised of the heads of major Federal departments that manage programs for people who are homeless, the Council convened the Federal Task Force on Homelessness and Severe Mental Illness in the early 1990s. When the Task Force released its 1992 report, *Outcasts on Main Street*, it provided a national strategy and a comprehensive framework for addressing homelessness among people with serious mental illnesses, many of whom have substance use disorders.

In particular, the Task Force recommended that Federal agencies help states and local communities develop *integrated systems of treatment, housing, and support services for people with serious mental illnesses who are homeless*. The framework for services outlined in *Outcasts on Main Street*—which included such key elements as outreach, case management, and a range of housing options—has withstood the test of time and rigorous evaluation, not only for people with serious mental illnesses but also for those with substance use disorders and co-occurring mental illnesses and substance use disorders, as well.

Federal demonstration programs, particularly those of SAMHSA's Center for Mental Health Services and Center for Substance Abuse Treatment (CSAT), and the experience of hundreds of community-based providers, have demonstrated that residential stability is a goal desired by, and attainable for, most people with serious mental illnesses and substance use disorders who become homeless. Key Federal efforts designed to prevent and end homelessness for people with serious mental illnesses and substance use disorders are highlighted below.

McKinney Research Demonstration Programs

Homeless Adults with Serious Mental Illnesses. Begun in 1990, this program was designed to test hypotheses from earlier research studies by developing effective service models for people with serious mental illnesses who are homeless. The five resulting projects were among the first longitudinal, experimental-design studies of housing and service interventions for this population. Each site was required to provide or arrange for outreach, intensive case management, mental health treatment, staff training, and service coordination. Results indicated that *even people with the most serious mental illnesses who are homeless, once thought to be unreachable and difficult-to-serve, can be reached by the service system, can accept and benefit from mental health services, and, with appropriate supports, can remain in community-based housing* (CMHS, 1994).

Homeless Adults with Substance Use Disorders. Between 1988 and 1993, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), in consultation with the National Institute on Drug Abuse (NIDA), funded two rounds of demonstration projects. In all, 23 projects were funded to provide and evaluate community-based alcohol and drug abuse treatment and rehabilitative services for individuals with substance use disorders who were homeless or at imminent risk of becoming homeless. Results indicated that *individuals with substance use disorders who are homeless need (1) services that address their tangible needs for housing, income, and employment; (2) access to flexible, low-demand interventions; and(3) long-term continuous treatment and support*. Researchers found that short-term treatment was ineffective with this group (McMurray-Avila, 2001).

SAMHSA/CMHS Homeless Programs

Access to Community Care and Effective Services and Supports (ACCESS).
The ACCESS program was designed specifically to test the hypothesis that
integrated service systems will improve individual functioning, quality of life,
and housing outcomes for people with serious mental illnesses who are homeless.
Begun in 1993, the 5-year demonstration program featured 18 communities in 9
states that were provided funds to enhance services, particularly outreach and
case management, for the target population. One community in each state was
designated the experimental site and was given additional funding to support
systems integration activities.

Results revealed that *systems integration has a positive impact on housing
outcomes for people with serious mental illnesses who are homeless*. In addition
to improved residential stability, individuals who received case management,
treatment, and support services showed a marked decrease in mental symptoms,
drug use, and minor criminal activity, and an increase in number of days worked
(Rosenheck et al., 1998; CMHS, 2001a).

Supported Housing Initiative. Begun in 1997, the Supported Housing Initiative
was a two-phase, multisite study designed to examine and compare the
effectiveness of various housing approaches for people with serious mental
illnesses, many of whom were or had been homeless. Researchers compared a
supported housing approach to other housing models on a number of outcome
measures, including residential stability, housing satisfaction, quality of life, and
empowerment. Findings from this study will identify key ingredients of the
housing models, their effectiveness, and their relative costs to help inform policy
and service program design (CMHS, 2001b).

Projects for Assistance in Transition from Homelessness (PATH). CMHS
provides ongoing leadership for people with serious mental illnesses who are
homeless through its administration of the PATH formula grant program. PATH
was created under the McKinney Act to provide funds to each state, the District
of Columbia, Puerto Rico, and four U.S. territories to support service delivery to
individuals with serious mental illnesses, including those with co-occurring
substance use disorders, who are homeless or at risk of becoming homeless.

Through outreach, case management, screening and assessment, staff training,
alcohol and drug treatment for people with co-occurring disorders, and support
services in housing, PATH-funded providers nationwide have set a standard for
the delivery of services to people with serious mental illnesses who are homeless.
In 2001, with an allocation of nearly $36 million, 399 local PATH-funded
organizations served more than 64,000 people with serious mental illnesses.

SAMHSA/CSAT Homeless Programs

In 2001, CSAT received $10 million to administer the Homeless Addiction
Services Initiative that supported grants to local nonprofit and public entities for

the purpose of developing and expanding substance abuse services for people who are homeless. In 2002, CSAT, in coordination with CMHS developed and expanded community–based mental health and substance abuse treatment services for people who are homeless through the Grants for the Benefit of Homeless Individuals (GBHI). To date, CSAT and CMHS have jointly funded approximately 19 million in grants under GBHI. These funds support local public and nonprofit agencies for up to three years to provide either substance abuse services, mental health services, or both, allowing communities the flexibility to provide the services they believe to be most urgent. Both CSAT programs will enable communities to expand their capacity to provide treatment to people with mental illnesses and substance use disorders who are homeless, and to learn more about effective interventions.

SAMHSA Collaborative Demonstration Programs

Co-occurring Disorders. SAMHSA's CMHS and CSAT initiated a study in 1993 to test the effectiveness of different approaches to treating people with co-occurring mental illnesses and substance use disorders who are homeless. Cross-site findings indicated that *an integrated approach is superior to a parallel or a sequential approach to treatment for co-occurring mental health and substance use disorders.* Integrated treatment for co-occurring disorders reduced alcohol and drug use, homelessness, and the severity of mental health symptoms (CMHS and CSAT, 2000a).

Preventing Homelessness. In 1996, CMHS and CSAT launched a two-phase, 3-year initiative to document and evaluate the effectiveness of homelessness prevention interventions. These interventions focused on people with serious mental illnesses and substance use disorders who were formerly homeless or at-risk for homelessness, and who were engaged with the mental health and/or substance abuse treatment system(s). Prevention activities included supportive housing, residential treatment, family support and respite, and representative payees and money management. Results revealed that *participants in the intervention programs showed improved treatment outcomes and residential stability*. Programs that could offer direct access to housing, as opposed to linkage and referral, had the strongest housing stability and retention outcomes (DeLeon et al., 2000; Bebout et al., 2001; Tsemberis and Eisenberg, 2000; Coughey, 2000; Policy Research Associates, 2001.)

Interventions for Homeless Families. Begun in 1999, CMHS and CSAT jointly fund and administer the Homeless Families Program. The 5-year program is designed to document and evaluate the effectiveness of time-limited, intensive interventions for providing treatment, trauma recovery, housing, support, and family preservation services to homeless mothers with mental illnesses and/or substance use disorders caring for their dependent children. A 3-year outcome evaluation phase, which includes both cross-site and site-specific studies of the interventions, began in 2001. Findings from the program will identify effective approaches for moving families from homelessness to housing, and for providing treatment and supports to help maintain residential stability and recovery (CMHS and CSAT, 2000b).

Understanding the Population

Research and practice reveal that communities can reach out to people with serious mental illnesses and substance use disorders; engage them in treatment; and create local partnerships to increase availability and access to affordable housing, employment, and treatment and supports to help prevent and end homelessness. Understanding how to do so, however, begins with knowledge about why people with serious mental illnesses and substance use disorders are vulnerable to becoming homeless and why they have a difficult time exiting homelessness. The next chapter examines individual vulnerabilities and systemic barriers in more detail.

C H A P T E R

■ **2**

Learn about the Population

People who are homeless are people first. *They also may have disorders including serious mental illnesses and substance use. The fact that they have illnesses that may significantly disrupt their lives doesn't diminish their rights, their responsibilities, or their dreams. People with serious mental illnesses and/or co-occurring substance use disorders become homeless because they are poor, and because mainstream health, mental health, housing, vocational, and social services programs are unable or unwilling to serve them. They also are subject to ongoing discrimination, stigma, and even violence.*

People with serious mental illnesses and/or co-occurring substance use disorders can and do recover.

For example, probably no condition is as closely connected with homelessness as chronic alcohol dependence (Baumohl and Huebner, 1991). As Stark (1987) notes:

> Conceivably, the homeless could have been stereotyped as unemployed men who needed jobs or job training, as elderly people who needed our concern and care, or as individuals who were physically and mentally disabled. Because, instead, they were stereotyped as alcoholics, the societal answer to their problems often related to some form of institutionalization, whether jail or detoxification program. (p. 12)

Unfortunately, some key facts about serious mental illnesses and substance use disorders are widely unrecognized or misunderstood. The most important fact is that *people with serious mental illnesses and/or co-occurring substance use disorders can and do recover*. Indeed, from a medical perspective, most mental illnesses today are considered to be as treatable as general medical conditions (HHS, 1999). Further, from a rehabilitation perspective, people with serious mental illnesses move beyond their disabilities to reclaim valued roles in society (Ahern and Fisher, 2001).

People with substance use disorders recover, as well. Fifty-five percent of individuals who remain in Alcoholics Anonymous for more than 90 days will be sober after one year, and 50 percent will be sober after five years (Ringwald, 2002). The very fact that people who have serious mental illnesses and substance use disorders have learned to survive on the streets speaks to their strength, their resiliency, and their perseverance, all protective factors that can be harnessed to help them recover.

To help people with serious mental illnesses and/or co-occurring substance use disorders avoid becoming homeless or exit homelessness, communities and providers must understand who they are and why they are vulnerable. This chapter examines (1) individual risk factors, (2) service delivery challenges, and (3) societal or structural factors that make it difficult for people with serious mental illnesses or co-occurring disorders to escape homelessness.

INDIVIDUAL RISK FACTORS

Mental Illness

Though only about five percent of people with serious mental illnesses are homeless at any given point in time, as many as two-thirds of all people with serious mental illnesses have experienced homelessness or have been at risk of homelessness at some point in their lives (Tessler and Dennis, 1989). The numbers are staggering, but they only begin to tell the story.

The symptoms of serious mental illnesses[1] may increase vulnerability to homelessness. Depending on the disorder, people with a mental illness may experience a range of behaviors that threaten their housing stability. Individuals whose mental illnesses or co-occurring substance use disorders are untreated may disturb their neighbors, be a threat to themselves or others, miss rent or utility payments, or neglect their housekeeping, and be evicted.

Serious mental illnesses can be cyclic in nature, and some individuals may experience a recurrence or exacerbation of their symptoms in situations that seem stressful or unpredictable. Further, because many people with mental illnesses have difficulty developing and maintaining comfortable social relationships, they may become lonely and isolated and have conflicts with family, employers, landlords, and neighbors. These conflicts can result in homelessness if

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1 For the purpose of the *Blueprint*, "serious mental illness" refers to having one or more of the following: diagnosed mental illness, diagnosable mental illness, condition attributable to a mental illness or co-occurring health conditions that include mental illness. The disorder is associated with significant limitations in the performance of one or more major life activities, including but not limited to the following: basic activities of daily life (e.g., bathing, eating, care for health condition), instrumental activities of daily life (e.g., domestic activities or managing money), interpersonal relations (e.g., regulating aggressive behavior), or school or work. The disorder has endured or can be expected to endure continuously or with major episodes for at least one year.

appropriate treatment and services are not available. People who are hospitalized or jailed may lose their housing when they are unable to pay their rent.

Alcohol and Drug Use

Substance use is both a precipitating factor and a consequence of being homeless (Zerger, 2002). Notes McCarty (1990, p.1):

> Street life for homeless men and women abusing drugs and alcohol can be confusing, dangerous, and frustrating. Individuals shuffle unsteadily between detoxification centers, shelters, bus stations, subways, day programs, jail, abandoned buildings, and soup kitchens. It is a painful life complicated by, but also made more bearable because of, the use and abuse of alcohol.

Researchers estimate that as many as half of all people who are homeless have diagnosable substance use disorders at some point in their lives (McMurray-Avila, 2001; Baumohl and Huebner, 1991). Alcohol abuse is more common, occurring in as many as 30 percent to 40 percent of people who are homeless (Stark, 1987; Baumohl and Huebner, 1991). Indeed, there still exists a cadre of older, white male, skid row alcoholics (Koegel and Burnam, 1987). Increasingly, however, individuals who are homeless and have substance use disorders are younger and include women, minorities, poly-drug users, and individuals with co-occurring mental illnesses (McMurray-Avila, 2001). They have less education and fewer skills than their older counterparts.

Substance use and abuse frequently lead to loss of housing, and make it more difficult for individuals to find safe, sober housing once they become homeless. People with substance use disorders who are homeless face enormous competition for limited treatment slots. Those who do receive treatment are more likely to get care for a co-occurring mental illness (SAMHSA, 2002a).

Co-occurring Disorders

Substance use problems are a complicating factor for many people who have serious mental illnesses. An estimated 50 percent of adults with serious mental illnesses who are homeless have a co-occurring substance use disorder (Fischer and Breakey, 1991). Among veterans who are homeless, one-third to nearly one-half have co-occurring mental illnesses and substance use disorders (Kasprow, Rosenheck et al., 2002).

People with both disorders are at greater risk for homelessness because they tend to have more severe mental symptoms, to deny both their mental illness and their substance use problems, to refuse treatment and medication, and to abuse multiple substances. Untreated, they may be antisocial, aggressive, and sometimes violent, and they have high rates of suicidal behavior and ideation.

Once homeless, people with co-occurring disorders have more problems, need more help or are unable to benefit from services, and are more likely to remain homeless than other groups of people (Winarski, 1998). They are more likely to

be older, male, and unemployed; to be homeless longer and living in harsher conditions; and to suffer greater distress, demoralization, and alienation from their families. They tend to be isolated, mistrustful, and resistant to help (Dixon and Osher, 1995). Lack of appropriate treatment for co-occurring disorders means that even individuals who are motivated to get help may be unable to find it or have to face long waits.

Physical Health Problems

People with serious mental illnesses and/or co-occurring substance use disorders often have significant co-morbid medical conditions, including malnutrition, diabetes, liver disease, neurological impairments, and pulmonary and heart disease. Homeless people with alcohol disorders are in especially poor health; they experience both the deleterious effects of alcohol and of homelessness (Wright and Weber, 1987). Further, life on the streets makes it difficult for individuals to receive appropriate care for chronic conditions and often leads to such acute problems as upper respiratory infections, skin conditions, and serious dental health problems. In addition, people who are homeless, particularly those with serious mental illnesses or co-occurring disorders, are at risk for life-threatening infectious diseases such as tuberculosis, Hepatitis B and C, and HIV/AIDS (Federal Task Force on Homelessness and Severe Mental Illness, 1992; McMurray-Avila, 2001).

Victimization

The relationship among homelessness, mental illness, substance use, and victimization—including physical and sexual abuse—is multidimensional. People who have been abused are more vulnerable to ongoing stresses that may lead to mental illness, substance use, and homelessness. While the association between childhood abuse, mental illness, and substance use is increasingly recognized, a number of studies have found high rates of childhood physical and sexual abuse in adults who are homeless, as well (Fischer, 1992). Indeed, research points to high prevalence rates of sexual abuse and other trauma in the lives of people with serious mental illnesses and substance use disorders who are homeless, particularly women (Goodman et al., 1995; Herman et al., 1997).

In studies that ask about lifetime abuse, between 51 and 97 percent of women with serious mental illnesses report some form of physical or sexual abuse, with a significant portion suffering multiple traumas (Goodman et al., 1997). Forty-one percent to 71 percent of women in treatment for drug or alcohol disorders report being sexually abused as children or adults, and more than one-third have been victims of violent crimes (Alexander, 1996).

Abuse in childhood may leave individuals vulnerable to ongoing abuse in adult relationships. For some women, domestic violence precipitates homelessness. Mental health providers may treat women who have experienced physical and sexual abuse inappropriately by using such techniques as physical restraints or forced medication that may remind the women of the original abuse they suffered (National Association of State Mental Health Program Directors [NASMHPD],

1998). These women require trauma-sensitive services to help them regain psychiatric and residential stability.

Finally, people who are homeless may become victims of further assault on the streets and in shelters. Those individuals who have fewer resources and skills to overcome the effects of trauma—especially people who have serious mental illnesses, including post-traumatic stress disorder (PTSD)—are particularly likely to be victimized while homeless, and to suffer more severe consequences of ongoing abuse (Fischer, 1992).

Minority Status

Racial and ethnic minorities are dramatically overrepresented among homeless populations. Nationally, compared to all U.S. adults in 1996, individuals who were homeless were disproportionately Black non-Hispanics (40 percent versus 11 percent in the general population) and American Indians (8 percent versus 1 percent in the general population) (Burt et al., 1999). Though these percentages vary around the country, research shows that people of color comprise a disproportionate share of the homeless populations in their communities (Burt, 1999).

Some of these groups are at heightened risk for substance use disorders. The highest rates of alcoholism in the homeless population are found among American Indians, both men and women (Wright, 1987). Crack cocaine use is prevalent among homeless African-American men and women in urban areas (Zerger, 2002).

Further, racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care, and the services they do receive are likely to be poor in quality (HHS, 2001).

Inattention to race and ethnicity creates significant barriers to successful treatment. Race, ethnicity, and culture influence how individuals express mental health problems, how they seek help, and how their problems can best be resolved (HHS, 2001). In addition, different racial and ethnic minorities respond differently to psychiatric medications (SAMHSA, 2002b).

Race and ethnicity also are major factors in defining alcohol and drug use and corresponding treatment needs. For example, "the needs, perspectives, and social networks of younger African Americans addicted to crack cocaine will differ from those of older White skid-row-type alcoholics, and neither of these groups will have the same characteristics as chemically dependent Mexican Americans and Native Americans" (Conrad et al., 1993, p. 239). People of color who feel disconnected from society and have untreated mental illnesses and/or co-occurring substance use disorders may be difficult to engage into treatment, especially if outreach workers and treatment staff are not sensitive to their cultural and linguistic needs.

Sexual Minorities

Homeless sexual minorities, especially youth, also are at increased risk for negative outcomes. Forty-two percent of homeless youth identify as lesbian, gay, or bisexual (Orion Center, 1986). Researchers comparing gay, lesbian, bisexual, and transgender (GLBT) homeless youth with their heterosexual counterparts found that GLBT adolescents left home more frequently, were victimized more frequently, used highly addictive substances more frequently, had higher rates of psychopathology, and had more sexual partners than heterosexual homeless youth (Cochran et al., 2002).

Transgender individuals are especially stigmatized. They may become homeless as a direct result of job or housing discrimination. Researchers report that as many as 60 percent have been victims of harassment or violence, and 37 percent have experienced economic discrimination (Lombardi, 2001).

Diminished Social Supports

People with mental illnesses who become homeless have less contact with their families and are more likely to have poor family relationships than those who are not homeless. Relationships often deteriorate over time, as parents or other relatives become exhausted and frustrated caring for a relative who may have recurring periods of disturbing or frightening behavior. Without the ongoing care and persistent advocacy that family members provide, many people with serious mental illnesses are at greater risk for homelessness.

Likewise, people with substance use disorders who are homeless have less social support than people who are not homeless. Yet, interestingly, among homeless groups, people who drink tend to report more support than people who don't drink, in part because drinking can be a social activity (Fischer and Breakey, 1987). Severing the bonds with their "friends" who use alcohol or drugs may compound feelings of social isolation among people who are homeless (McMurray-Avila, 2001).

Criminal Justice System Involvement

Homeless people, especially those with mental illnesses and/or co-occurring substance use disorders, come into frequent contact with the criminal justice system both as offenders and as victims. Often, homeless people are arrested for minor offenses, including trespassing, petty theft, shoplifting, and prostitution.

Studies reveal that a person with a mental illness has a 64 percent greater chance of being arrested for committing the same offense as a person who does not have a mental illness (Teplin, 1984). A person's contact with the criminal justice system may be even more likely following the enactment of "anti-homeless" legislation, including anti-begging, sleeping, and vagrancy ordinances, which is occurring in many of the country's largest cities (National Coalition for the Homeless [NCH] and National Law Center on Homelessness and Poverty, 2002).

People with substance use disorders who are homeless are more likely than persons who have not experienced homelessness to have arrest histories, to have been arrested in the past year, and to report felony convictions (Fisher and Breakey, 1987). Fifty percent of all arrests of homeless people relate to drinking in public spaces (McMurray-Avila, 2001).

Though some individuals with serious mental illnesses or co-occurring mental illnesses and substance use disorders are diverted to treatment, the U.S. Department of Justice (DOJ) reports that nearly 284,000 people with mental illnesses were in jails and prisons in 1998 (Ditton, 1999). Twenty percent of state prison inmates, 19 percent of Federal prison inmates, and 30 percent of local jail inmates with mental illnesses were homeless in the year before their arrest (Ditton, 1999). In addition, offenders report a high incidence of substance use, and more than half are under the influence at the time of their crime (CSAT, in press). Among detainees with mental illnesses, 72 percent also have a co-occurring substance use disorder (Ditton, 1999).

Despite research findings that people with substance use disorders benefit in particular from treatment while incarcerated, individuals with serious mental illnesses or co-occurring disorders may receive inadequate or inappropriate treatment in jails and prisons, if they receive any at all. Without an appropriate discharge plan, they are vulnerable to repeat cycles of homelessness.

Finally, as noted previously, people with serious mental illnesses and/or co-occurring substance use disorders living on the streets or in shelters frequently are victims of criminal activity. Poverty, poor survival skills, and illegal activity place people with serious mental illnesses or co-occurring disorders in dangerous situations in which they are vulnerable to attack (Fischer, 1992).

SERVICE SYSTEM CHALLENGES

Fiscal Barriers

Treatment Gaps

Significant fiscal barriers prevent people with serious mental illnesses and/or co-occurring substance use disorders from receiving the care they need. Perhaps the most important of these are the ways in which limited funds are used in both the mental health and substance abuse treatment systems, which can result in significant gaps in the ability of both systems to treat people in need.

Estimates are that about 20 percent of the U.S. population is affected by mental illnesses in any given year, but only one-third of people in need of mental health treatment receive it (HHS, 1999). On the substance use side, a recent report estimates that some 23 million people need treatment for alcoholism or the use of

illicit drugs, but fewer than one-quarter of individuals receive it (Horgan et al., 2001).

Coverage Gaps

There are gaps in coverage, as well. The critical work of finding and engaging people who have serious mental illnesses and/or co-occurring substance use disorders into treatment is often not a reimbursable service. Payers who fund mainstream mental health and substance abuse treatment services favor clinic and institution-based care (Post, 2001). For example, Medicaid is a joint Federal/state program but is state-administered, and states vary considerably in the degree to which they conduct outreach to homeless people. Though Medicaid has instituted some outreach efforts, they are not specifically targeted to homeless people (GAO, 2000a).

When case management is available to people who are homeless, caseloads are usually high, permitting little more than office-based contact and infrequent monitoring. Providers struggle to pay for services provided in atypical settings, such as shelters and on the streets, or nonmedical services, such as social model substance abuse treatment programs.

Further, providers may be reluctant to serve people with no health insurance coverage, which is the case for many people with serious mental illnesses and/or co-occurring substance use disorders who are homeless. Many are eligible for, but unable to access, these benefits. Those covered by Medicaid or Medicare often are not attractive to providers in managed care systems that receive less reimbursement than they would under a fee-for-service arrangement (Bianco and Milstrey-Wells, 2001).

 Persons with disabilities may be eligible for support through the Social Security Administration's Social Security Income (SSI) or Social Security Disability Insurance (SSDI) programs. Persons who are poor and disabled or elderly may be eligible for the SSI program. Persons who have a sufficient work history and become disabled may be eligible for the SSDI program. Homeless people who have substance use disorders are less likely than those with serious mental illnesses or co-occurring disorders to be receiving Federal disability benefits (Baumohl and Huebner, 1991). This is in large part because individuals with substance use disorders, no matter how severe, are not considered disabled under Social Security Administration guidelines for the purpose of receiving SSI, unless they have other disabling health conditions not attributable to their substance use.

However, people with substance use disorders often are unable to establish SSI eligibility without a coordinated effort to document the qualifying disability and consistent advocacy through the application and appeals process (C. Wilkins, personal communication, April 1, 2003). Also, even if SSI eligibility is established and the person is qualified for Medicaid, many states offer limited Medicaid coverage for substance abuse treatment services.

Categorical Funding

Finally, categorical funding—which requires that providers offer only a specific type of service with funds from a particular source (Federal, state, local, private, etc.)—may make it difficult to tailor services to individual needs. In its report, *Ending Chronic Homelessness: Strategies for Action*, the U.S. Department of Health and Human Services (HHS) uses the phrase "funding silos" to describe this problem, which arises in part because most mainstream programs administered by HHS were created to respond to a unique need or population (HHS, 2003). The same is true for categorical programs in other Federal agencies, as well as in state and local programs.

Funding silos lead to problems in coordination, eligibility, and flexibility, the HHS report notes. This is especially problematic for individuals whose disabilities cross service system boundaries. For example, few mainstream or targeted assistance programs pay for the sustained engagement and motivational efforts required to treat homeless people with co-occurring mental illnesses and substance use disorders. The HHS report notes:

> The most telling example of [eligibility gaps] involves homeless persons with substance use disorders and co-occurring mental illnesses and primary health care problems. They may have access to limited substance abuse treatments supported by the Substance Abuse Prevention and Treatment Block Grant. But, they may find that they do not meet eligibility criteria for receipt of Medicaid coverage, nor qualify as having a serious and persistent mental illness for access to services supported by the Community Mental Health Services Block Grant (p. 20).

Categorical funding also is likely to cause gaps in coverage as an individual prepares to exit homelessness and is required to deal with multiple service agencies, each with its own case management staff (HHS, 2003).

Fragmented Services

People with serious mental illnesses and/or co-occurring substance use disorders who are homeless require a broad range of housing, health and mental health care, substance abuse treatment, and social services, all of which typically are provided by separate agencies with separate funding streams. The burden of coordination falls on the individual, but people with serious mental illnesses or co-occurring disorders, especially those who are homeless, are ill-prepared to negotiate a fragmented service system unaided.

Lack of Discharge Planning

Service system fragmentation is especially evident in the transition from an institution, such as a hospital or jail, to the community. Some people with serious mental illnesses may be released from a hospital before their symptoms are stabilized adequately, especially if their health insurance plan specifies a

predetermined length of stay. Others are released without adequate discharge plans. As noted previously, people with substance use disorders may be discharged from detoxification programs back to the streets.

A lack of coordination between the hospital and community-based providers to ensure appropriate housing, treatment, income, and supports means these individuals fall through the cracks in the system and may become homeless. Many local officials also cite the absence of available resources as a significant barrier to helping people successfully make these transitions (Rickards and Ross, 1999).

The same is true for individuals leaving jails and prisons. Nationally, only one-third of inmates with mental illnesses in jails and prisons receive any discharge planning services. Frequently, they are released with bus tokens, a few pills, and the address of a mental health center (Bazelon Center for Mental Health Law, 2001). They are subject to further arrest or to unnecessary hospitalization as they attempt to cope with their mental illnesses and life on the streets. Likewise, individuals with substance use disorders who are not connected to appropriate community services are more likely to cycle repeatedly between jail or prison and the community.

Lack of Integrated Treatment for Co-occurring Mental Illnesses and Substance Use Disorders

Substance abuse is an issue for at least half of all people with serious mental illnesses who are homeless. Typically, mental health and substance abuse services are provided by two separate systems, placing the burden of combined treatment on the individual and leading to higher rates of treatment noncompliance. People who are homeless also interact with the homeless service system.

People with co-occurring disorders who are homeless frequently are excluded from mental health treatment programs because of their substance use disorder, from substance abuse treatment programs because of their mental illness, and from homeless service programs because of their mental illnesses and substance use disorders. Those who do receive care may get treatment for their substance use or their mental illness, but the vast majority of individuals do not receive treatment for both (Watkins et al., 2001). More recent models emphasize the integration of mental health and substance abuse treatment for people with the most serious disorders, but few such programs are available (SAMHSA, 2002b).

Inadequate Screening and Assessment

Screening and assessment of people with serious mental illnesses and/or co-occurring substance use disorders can be problematic in the best of circumstances, but homelessness adds another layer of difficulty. Outreach workers may conduct an initial assessment, which often has to be short and unobtrusive to avoid frightening away potential clients. A more complete

assessment may be possible when clients have developed a greater degree of trust and comfort with outreach staff (Interagency Council on the Homeless, 1991).

Adequate initial assessment of persons with serious mental illnesses or co-occurring disorders is made more difficult by the fact that shelter staff may lack the training or time to conduct a thorough psychiatric assessment, and there are few reliable screeners for co-occurring disorders. There are, however, some agreed upon early assessment tools for substance use disorders. A study of different assessment methods in Boston's Long Island Shelter found that case managers could identify substance use problems by using a set of open-ended questions that include information on consumption patterns and personal problems associated with drinking (Garrett and Schutt, 1987).

Self-reported substance use is a common assessment method, but the validity of self-reports has been called into question by several studies indicating that people vastly underreport the use of substances, especially illicit drugs (Zerger, 2002). An Institute of Medicine report on the treatment of alcohol problems notes that the validity of self-reports is decreased when items on the assessment are vague or overly general, contact with the respondent is brief, or the respondent is not aware that self-reports will be checked against other sources of information (Institute of Medicine, 1990).

Determining the presence of serious mental illnesses in a person with a substance use disorder, or the presence of a substance use disorder in a person with a mental illness, is particularly difficult. Symptoms of mental illnesses and substance use may mimic or mask each other. Research indicates that identifying substance use disorders in acute-care psychiatric settings has been especially problematic, with rates of nondetection as high as 98 percent (Ananth et al., 1989). While numerous instruments are available to assess mental illnesses or substance use, no single, agreed-upon assessment tool exists for co-occurring disorders (SAMHSA, 2002b).

Lack of Access to Mainstream Services

People who are homeless and have serious mental illnesses and/or co-occurring substance use disorders are eligible for a host of mainstream health, social service, and income support programs that are intended to meet the needs of all low-income people, not only those who are homeless. Though such programs are a valuable resource for providing needed services and supports, people who are homeless often face significant enrollment barriers (Post, 2001).

For example, regulations may restrict eligibility for certain programs. Some individuals, such as single homeless adults without children, particularly those with substance use disorders and/or a history of felony or drug convictions, have limited eligibility for mainstream services. Individuals with a primary diagnosis of a substance use disorder, for instance, are excluded from receiving Federal SSI benefits. Other barriers include complicated application procedures and requirements made even more difficult by the lack of a fixed address or documentation required to apply for and receive benefits (HHS, 2003; GAO,

2000a; SAMHSA and Health Resources and Services Administration [HRSA], 2002c).

Further, many mainstream service providers have neither the resources nor experience to provide people who are homeless with many of the services and benefits for which they are eligible. In the absence of incentives to do so, many mainstream programs often fail to reach out to and serve people who are homeless, viewing it as a low-priority or as the responsibility of the homeless service system (SAMHSA and HRSA, 2002c).

Lack of Client-Centered Services

Many people with serious mental illnesses and/or co-occurring substance use disorders know what they need and how they want to be treated, but too often, their wants and needs are ignored. Treatment plans are designed *for* them, rather than *with* them, and their choices are limited. This affects both their willingness to engage in services and to remain in treatment.

Studies examining the perception of need among the general homeless population often find discrepancies between what individuals want and what providers believe they need. For example, in a recent nationwide study of homeless assistance providers and clients, individuals rated their top three needs as help finding a job, help finding affordable housing, and help with housing expenses (Burt et al., 1999). Nine percent of respondents mentioned alcohol and drug use treatment as something they needed "right now" (the 13th most frequent response), and five percent mentioned detoxification (Zerger, 2002).

Likewise, in a study of individuals entering the Center for Mental Health Services' Access to Community Care and Effective Services and Supports program, researchers found that 88 percent of their expressed needs were not being met (National Resource Center on Homelessness and Mental Illness, 1995). Oakley and Dennis (1996) conclude that "shelter, sustenance, and security needs should be met before addressing an individual's need for treatment."

Retention in treatment is a significant problem for people in alcohol and drug treatment, especially those who are homeless. A study of the National Institute on Alcohol Abuse and Alcoholism Cooperative Agreement Program found that all grantees lost two-thirds or more of their clients to premature exit, and the majority lost more than 80 percent, regardless of the particular intervention they chose (Orwin et al., 1999).

Some of the reasons for premature exit included lack of motivation, delay in starting treatment, and dissatisfaction with degree of program structure or program environment. In particular, individuals cited the need to give up their job or, for women, the inability to have their children with them, as reasons for leaving. When people with substance use disorders fail in treatment, they tend to return to the "highly precarious circumstances that precipitated their homelessness" (Orwin et al., 1999).

Individuals reluctant to follow through on treatment goals that do not meet their needs increase their vulnerability to homelessness. They are difficult to re-engage in services once they have had negative experiences with an unresponsive treatment system.

S OCIETAL R ISK F ACTORS

Poverty

People with serious mental illnesses are among the most impoverished in our Nation. The President's New Freedom Commission (2003) found that: "People with mental illnesses have one of the lowest employment rates of employment of any group with disabilities—only about 1 in 3 is employed". Because many are unable to work full-time, they must rely on public benefit programs, such as SSI. For many individuals with serious mental illnesses, such benefits provide their only means of support. As noted previously, people with substance use disorders are not eligible for SSI based on substance-related disability alone. Many work episodically, in part to support their addictions.

In 2001, the monthly SSI payment was $531. Even with SSI supplements, provided by fewer than half the states, SSI recipients remain well below the Federal poverty level. In addition, though eligible to receive benefits, many people with serious mental illnesses are not enrolled. They face significant enrollment barriers, including lack of appropriate documentation and complex application procedures. These hurdles are particularly difficult for people who are homeless. The absence of a fixed permanent address makes it difficult to apply successfully for benefits since information about required appointments or the status of one's application often is communicated by mail. Lack of benefits frequently leads to homelessness and the inability to exit homelessness.

Lack of Affordable Housing

A dearth of appropriate, accessible, and affordable housing is considered by many to be the number one barrier to residential stability for people with serious mental illnesses and/or co-occurring substance use disorders. Not one housing market in the United States exists in which an individual receiving SSI benefits can afford to rent a modest efficiency or one-bedroom unit. In 2000, people with disabilities receiving SSI needed to pay, on average, 98 percent of their SSI benefits to rent a modest, one-bedroom unit at fair market rent, as determined by the U.S. department of Housing and Urban Development (O'Hara and Miller, 2001).

Housing Barriers for People with Serious Mental Illnesses

Many people with serious mental illnesses qualify for Federal Housing Choice (formerly Section 8) vouchers. These subsidies require that people pay only 30

percent of their income for rent and utilities. However, many people are on waiting lists for years before they receive a subsidy. Also, receipt of a Housing Choice voucher does not guarantee housing, particularly where affordable housing is in short supply.

As a result, many people for whom SSI or SSDI are their only source of income are forced to live in overcrowded or substandard living environments that place them at physical and emotional risk. Others are living with aging parents or relatives, many of whom themselves are living on fixed, low incomes. Living precariously, people with serious mental illnesses are one small crisis—such as a rise in the cost of their medication—away from becoming homeless. Those who are doubled-up living with friends or other individuals in similar circumstances live at the whim of their hosts and may be evicted after a disagreement of even the most trivial matter.

Further, many mainstream affordable housing providers are reluctant to serve people with serious mental illnesses, especially those who have been homeless. That reluctance in part is because of the misperception that people with mental illnesses need supervision or round-the-clock support, and in part because of their low incomes and lack of credit history. Until recently, even many mental health professionals presumed that most people with serious mental illnesses required supervised, treatment-oriented, group living arrangements to be successful in their communities. Research, however, provides strong evidence that people with mental illnesses neither need to nor want to live in such settings (Carling, 1993).

Housing Barriers for People with Substance Use Disorders

Housing is especially problematic for people with substance use disorders, particularly for those with co-occurring mental illnesses. Their behaviors place them at high risk for eviction, arrest, and incarceration. Once homeless, they are unlikely to succeed in treatment without the availability of safe, sober housing (Baumohl and Huebner, 1991; Stark, 1987).

Few housing landlords (public or private), mental health agencies, and nonprofit developers will rent to people who are actively abusing alcohol or other drugs. Use of illegal drugs may be cause to deny admission or evict a person from federally assisted housing (Federal Register, 2001). Individuals who have engaged in drug-related criminal activity *must* be denied admission to public housing and most other federally assisted programs (Federal Register, 2001).

Discrimination and Stigma in Housing

Finally, despite statutes such as the Fair Housing Amendments Act, allegations of housing discrimination based on mental illnesses are common (HHS, 1999). Stigma and discrimination can be overt, such as vocal community opposition to group living situations, or they can be less obvious, such as steering public funds away from housing initiatives that serve controversial populations.

The so-called "not-in-my-back-yard" (NIMBY) syndrome may affect individuals or it may affect broader public policy that affects people with serious mental illnesses and substance use disorders in housing and in social and health services (Federal Task Force on Homelessness and Severe Mental Illness, 1992). "NIMBY-ism" was a significant problem faced by the NIAAA grantees when trying to site housing for people with substance use disorders who were homeless (Conrad et al., 1993).

Lack of Employment

People who are homeless want and need to work, but few are employed in jobs that can help them escape homelessness. A recent nationwide survey of homeless assistance providers and clients found that 44 percent of homeless people were working, but most were employed in short-term jobs with low pay and no benefits (Burt et al., 1999). An earlier study revealed that 80 percent of the homeless population in inner-city Los Angeles was unemployed, but 66 percent of individuals were looking for work (NIAAA, 1992).

Among people with serious mental illnesses, the unemployment rate hovers at 90 percent (HHS, 1999). Many people with serious mental illnesses are unable to work consistently, if at all, in part due to active symptoms of these illnesses. Frequently, they experience interruptions of education and employment. The low-paying, often menial jobs for which they qualify do not pay a living wage and usually do not include health care benefits, which leaves them vulnerable to becoming and remaining homeless. Further, many people who receive Federal income and entitlements are reluctant to seek employment because they fear the loss of benefits, including much-needed health insurance.

People with substance use disorders often exhibit problem behaviors that interfere with job success. In the previously cited Los Angeles study, homeless people with alcohol disorders were more likely than those without alcohol or other disorders to report not working at all in the past year, to have worked fewer months at a greater number of jobs, and to have experienced a longer time period since their most recent job. However, they tended to be more successful in recent job experiences than homeless individuals with mental illnesses (NIAAA, 1992).

Discrimination and Stigma Associated with Disabilities and Disadvantages

Statutes such as the Americans with Disabilities Act and the Fair Housing Amendments Act spell out the rights of people with disabilities and the penalties for discriminating against them. Still, discrimination and stigma associated with mental illness, co-occurring substance use disorder, and homelessness often are major impediments to accessing housing and services (SAMHSA and HRSA, 2002c).

For instance, people with substance use disorders may be "ostracized, discriminated against, and deprived of basic human rights. Their families,

treatment providers, and even researchers may face comparable stigmas and attitudes" (CSAT, 2002).

Further, despite the fact that public understanding of mental illnesses has grown since the 1950s, stigma and fear have increased. In a 1996 survey, the public's perception of mental illnesses was frequently associated with the fear of violence (HHS, 1999). Selective media reporting may reinforce negative stereotypes linking mental illnesses and violence, though studies have shown that the absolute risk of violence posed by persons with mental illnesses is small (HHS, 1999; Mulvey, 1994).

Complicating the issue, providers of mental health, substance use, and other social services may have negative attitudes toward serving people who are homeless. Discrimination by landlords and other housing and service providers, in turn, may lead to fear and mistrust on the part of individuals, causing them not to seek the housing and supports they need (SAMHSA, 2002a).

GUIDING PRINCIPLES FOR A SYSTEM OF CARE

Providers of services to people with serious mental illnesses and/or co-occurring substance use disorders and people who are homeless face a daunting challenge to address their clients' multiple, complex needs. But they cannot design programs *for* their clients; they must create them *with* their clients. Services for people with serious mental illnesses or co-occurring disorders who are homeless must be built on a foundation of core values that both *put people first* and support recovery from multiple conditions. The next chapter outlines a set of underlying principles to guide development of a comprehensive system of care for people with serious mental illnesses and/or co-occurring disorders who are homeless.

C H A P T E R

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Establish Core Values

The values that underlie development of community-based services for people

with serious mental illnesses and/or co-occurring substance use disorders who

are homeless are as important as the individual service components themselves.

Each of these values has at its center an abiding belief in the dignity and worth

of the individual.

Understanding the concept and practice of recovery is fundamental to the development of effective services.

Putting people first not only is the humane thing to do; but also it is the most effective way to help people with serious mental illnesses or co-occurring disorders escape homelessness. Research reveals that services that respect an individual's right of self-determination are more likely to result in residential and psychiatric stability and sobriety (Srebnik et al., 1995; Shern et al., 2000). This chapter examines (1) the concept and practice of recovery, (2) person-centered values, and (3) system-level values that form the foundation for effective services to prevent and end homelessness among people with serious mental illnesses or co-occurring disorders.

T H E   C O N C E P T   A N D P R A C T I C E   O F   R E C O V E R Y

The good news is that *people with serious mental illnesses and/or co-occurring substance use disorders can and do recover*. Understanding the concept and practice of recovery is fundamental to the development of effective services for people with serious mental illnesses and/or co-occurring disorders who are homeless.

A Definition of Recovery

There are as many different definitions of recovery as there are individuals who recover. However, as mental health and substance abuse treatment systems move toward recovery-based systems of care, many have developed working definitions to guide their efforts. The Connecticut Department of Mental Health and Addiction Services has endorsed a broad vision of recovery as:

a process of restoring or developing a positive and meaningful sense of identity apart from one's condition and then rebuilding a life despite or within the limitations imposed by that condition (Evans et al., 2002).

For many, if not most, homeless individuals who have mental illnesses and substance use disorders, recovery will involve some type of professional intervention, including the use of medication, where appropriate. Evidence-based and promising treatment practices for people with serious mental illnesses or co-occurring disorders who are homeless are discussed in the next chapter. The following discussion examines other critical facets of the recovery process.

Recovery from Substance Use Disorders

The term "recovery" has been used extensively in the field of substance use, where it refers to a return to sobriety (Ralph, 2000). For many individuals, spirituality and peer support are critical to their recovery from addictions. Thus, for example, individuals in 12-step groups for recovery from addictions express their belief in a power greater than themselves. Secular substance use recovery groups, such as Women for Sobriety and Self-Management and Recovery Training (SMART), focus on individual empowerment and emotional growth. They share with the 12-step tradition a belief in the importance of self-help as a way to obtain and maintain sobriety.

People with both a mental illness and a co-occurring substance use disorder face the daunting task of recovering from both disorders. Self-help groups specifically designed to meet the needs of people with co-occurring disorders, such as Double Trouble in Recovery, provide individuals the opportunity to share common problems and to help others in their recovery from both mental illnesses and substance use (Double Trouble in Recovery, 1997).

Recovery from Mental Illness

Use of the term "recovery" only recently has been applied to people with mental illnesses, in part because of the mistaken belief that having a serious mental illness is a lifelong condition. The most frequently cited study that disproves this notion is a longitudinal study of severely disabled individuals in Vermont. Investigators found that 34 percent of former hospital inpatients who received mental health services, including psychiatric rehabilitation, in the community achieved full recovery in both psychiatric status and social functioning, and an additional 34 percent improved significantly in both areas (Harding et al., 1987). Twenty-seven studies (including Harding's) published between 1960 and 1991 show equally promising rates of recovery from serious mental illnesses (Ralph, 2000).

More recent research examines the relationship between illness self-management, an evidence-based practice in the mental health field, and recovery from serious mental illnesses. Researchers found that illness self-management skills— including greater knowledge of mental illnesses, coping skills, and relapse

prevention strategies—play a critical role in people's recovery from mental illnesses (Mueser et al., 2002).

However, much of what is known about mental health recovery comes from the writings of mental health consumers themselves and supports what has been called the "simple yet powerful vision" (Anthony, 1993) of mental health recovery. Ultimately, recovery from a serious mental illness is a very personal process that involves the recovery of hope, of meaningful activities and relationships, and of self-esteem and self-worth. Many consumer advocates believe that recovery involves the development of both key relationships with supportive individuals and core beliefs about mental illnesses (Ahern and Fisher, 1999). Accordingly, they believe an individual can recover regardless of whether he or she takes medication.

Recovery from Homelessness

Recovery from homelessness also is a process, according to a study conducted by SRI Gallup, Inc. Researchers defined recovery from homelessness as being sober, employed, and housed; they identified six themes that support this process: spirituality, self-insight, security, self-awareness, support, and suppression of poor self-concepts and negative attitudes (www.agrm.org/gallup.html, retrieved May 2, 2003).

Lack of support or connection to others may be the single most important reason why people are homeless, according to the SRI Gallup survey. For many homeless people, outreach workers are the first to break through the isolation and begin to move people toward a life of greater health and personal stability. Outreach is about "compassion translated into concrete action. It is about regarding all human beings as intrinsically valuable." (Kraybill, 2002). Person-centered values are at the heart of a system that empowers people with mental illnesses and substance use disorders to recover.

P E R S O N - C E N T E R E D V A L U E S

The key values that support recovery can be described in a number of ways. For example, people with mental illnesses and substance use disorders who have survived trauma (defined as physical or sexual abuse) speak of "safety, voice, and choice" as the values that must guide services designed by and for them (NASMHPD, 1998). Researchers trying to quantify recovery to make it measurable use the terms "hope, taking personal responsibility, and getting on with life" (Noordsy et al., 2002). Spirituality and self-help are key tenets of the 12-step approach to addictions.

While these values are described similarly, some important points stand out.

Choice. People with serious mental illnesses and/or co-occurring substance use disorders who are homeless should be given *real* choices in housing, treatment,

and support services. They should be informed of the full array of options available to them. Services cannot be "one size fits all"; they should be tailored to the individual's needs.

Voice. A well-known tenet of the mental health consumer movement says, "*Nothing about us without us*." People who have serious mental illnesses or co-occurring disorders should have a say in the programs, policies, and services designed to serve them.

Empowerment. Many people with serious mental illnesses or co-occurring disorders, especially those who are or have been homeless, are disillusioned with services they have received in the past and are disenfranchised from the service system. They should be *educated* and *empowered* to make choices in matters affecting their lives and to accept *responsibility* for those choices (Federal Task Force on Homelessness and Severe Mental Illness, 1992). For most, this should include participation in developing their treatment goals and recovery plan.

Dignity and Respect. The use of *people first* language (e.g., *people* who have serious mental illnesses, *people* who are homeless) is more than an exercise in semantics. Language shapes thought, and treatment service providers must recognize that the people they serve deserve the same respect that providers expect from them.

Hope. Hopelessness breeds helplessness and despair. For many, *recovery of hope is essential for recovery from serious mental illnesses or co-occurring disorders*. Recovery from these disorders is an achievable goal that makes all other goals possible.

SYSTEM-LEVEL VALUES

A recovery-oriented system of care, according to the Connecticut Department of Mental Health and Addiction Services, "identifies and builds upon each individual's assets, strengths, and areas of health and competence to support achieving a sense of mastery over his or her condition while regaining a meaningful, constructive sense of membership in the broader community" (Evans et al., 2002). Specific system-level values that can help achieve this vision include:

Believe in Recovery. Optimism is essential. Osher (1996) notes: "Consumers, families, and practitioners who maintain a hopeful attitude toward recovery are associated with effective [co-occurring disorders] treatment programs."

Make "Any Door the Right Door" to Services. People who are homeless and have serious mental illnesses and/or co-occurring substance use disorders should be able to enter the service system through any service "door" (e.g., mental health services, substance abuse treatment, welfare office, jail), should be assessed, and should have access to the full range of comprehensive services and

supports they want and need (National Technical Assistance Center for State Mental Health Planning [NTAC], 2000).

Use Mainstream Resources to Serve People Who Are Homeless. People with serious mental illnesses or co-occurring disorders who are homeless should be educated and empowered to gain access to mainstream resources (e.g., housing, mental health, and income support) for which they are eligible (Federal Task Force on Homelessness and Severe Mental Illness, 1992). Many people who become homeless are or have been clients of public systems of care and assistance, but they have been ill-served. Homeless assistance providers should help connect or reconnect individuals to mainstream programs, which is the only way to provide the long-term housing and services individuals require to break the cycle of homelessness (NAEH, 2000).

Be Flexible/Offer Low-Demand Services. Services should be flexible enough to be delivered in sufficient amounts, duration, and scope to support recovery, based on an individual's changing needs and preferences. Participation in treatment and receipt of services should not be required to gain access to housing. Individuals reluctant to enter treatment may require some type of low-demand service, such as a Safe Haven, to help engage them in more intensive interventions (see more about Safe Haven in Chapter 6). These strategies can provide safety and help meet immediate survival needs while providing an opportunity to engage individuals in more intensive interventions.

Tailor Services to Meet Individual Needs. Each individual's preferences, treatment history, strengths, needs, and motivations must be recognized and addressed in plans designed to help him or her avoid or exit homelessness (Federal Task Force on Homelessness and Severe Mental Illness, 1992).

Develop Culturally Competent Services. Race, ethnicity, and culture influence everything, from how individuals express problems to whether or not they seek help and the type of services they will accept. At its core, cultural competence involves improved access to services and cultural adaptations that make services appropriate in cross-cultural settings (PATH Cultural Competence Workgroup, 2001). At a minimum, providers should be multilingual and multicultural (Federal Task Force on Homelessness and Severe Mental Illness, 1992; HHS, 2001).

Involve Consumers and Recovering Persons. Mental health consumers and individuals in recovery from substance use disorders play an important role in helping to empower their peers to recover from serious mental illnesses or co-occurring disorders. They make valuable contributions as agency staff and as active members of planning councils and advisory boards. Many consumers and recovering persons operate programs and services designed to help their peers recover.

Offer Long-Term Followup Support. Recovery from mental illnesses and co-occurring substance use disorders is neither a linear nor a short-term process. Relapse is to be expected, and individuals may require long-term followup

support, especially after they move into housing or gain employment. Short-term fixes are neither cost-effective nor humane.

ESTABLISHING A SYSTEM OF CARE

Clearly, people with serious mental illnesses and/or co-occurring substance use disorders who are homeless have significant, complex needs that must be addressed if care is to be effective and recovery is to be achieved. The many state and community agencies that serve people with serious mental illnesses or co-occurring disorders who are homeless must work together to plan a comprehensive, coordinated system of care that supports their clients' individual needs for recovery from multiple conditions.

The next two chapters of this report comprise Section II: Plan for Services. They offer practical approaches for developing strategic partnerships and securing the support needed to begin.

PLAN FOR SERVICES

The needs of people with serious mental illnesses and/or co-occurring substance use disorders who are homeless cannot be addressed by a single service system. Indeed, both research and practice in recent years reveal that services for people with serious mental illnesses and/or co-occurring substance use disorders who are homeless must be offered as part of a comprehensive, integrated system of care. Partnerships with other providers and service systems can increase residential and clinical stability and prevent homelessness (Davis et al., 2002; Rosenheck et al., 1998).

Thus, community agencies that serve people with serious mental illnesses or co-occurring disorders who are homeless must work together to build a strong foundation for systems change and to secure the support needed to establish and maintain services. The next two chapters—Establish a Comprehensive, Integrated System of Care and Finance a Comprehensive System of Care—describe the steps necessary to help build those coalitions:

■ Develop the infrastructure for systems change;
■ Engage in strategic planning;
■ Participate in community-wide planning;
■ Streamline existing funding;
■ Secure additional resources; and
■ Leverage new funds.

Additional information on the materials cited in these chapters can be found in the References. Organizations that offer technical assistance in these areas are listed in the Resources section.

C H A P T E R

■ **4**

Establish a Comprehensive, Integrated System of Care

People with serious mental illnesses and/or co-occurring substance use

disorders who are homeless need multiple services, including housing, health

care, mental health services, substance abuse treatment, income supports and

entitlements, life skills training, education, and employment. These services

typically are provided by multiple agencies in different systems, leaving

individuals to coordinate their own care. They may receive duplicate services

at multiple agencies or no services at all. This chapter examines both the need

for a comprehensive, integrated service system, and the steps and strategies to

achieve systems change.

Without housing, services and supports cannot be effective.

W H Y   C O M P R E H E N S I V E , I N T E G R A T E D   S E R V I C E S ?

The concept of integrating human services to improve outcomes for individuals with multiple and complex needs is not new. For more than 30 years, active efforts to integrate human service systems have been called by such names as community integration, comprehensive services, community support systems, and a Continuum of Care (Dennis et al., 1999). In its 1992 report, *Outcasts on Main Street*, the Federal Task Force on Homelessness and Severe Mental Illness set as a goal for the Nation, "an integrated service system for homeless people with severe mental illness." Clearly, progress has been made, but much remains to be done.

Systems integration efforts have taken on special urgency in an era of increasing needs and limited resources. Contemporary systems integration efforts are driven by several important factors. The relaxation of some Federal program regulations—through block grants and special waivers, for example—creates opportunities to promote integrated services. In addition, some Federal/state programs, including Medicaid managed care and welfare reform, may prompt collaboration among diverse agencies in order to meet mandated financial objectives and client outcomes (NASMHPD and CMHS, 1999).

The Definition of Systems Integration

At its most basic, systems integration is designed to change service delivery for a defined population and involves fundamental changes in the way agencies share information, resources, and clients (Dennis et al., 1999). In particular, systems integration focuses on reducing barriers, coordinating and improving existing services, and developing new programs to improve the availability, quality, and comprehensiveness of services (Miller, 1996).

Systems integration efforts require the creation of formal relationships among agencies within and across systems. Systems integration cannot succeed without an emphasis on integrated services, as well (Agranoff, 1991; Cocozza et al., 2000).

The Creation of a Seamless System of Care

The ultimate goal of systems integration is to improve outcomes for people with serious mental illnesses or co-occurring disorders who are homeless. To do so requires creating a system of care that is seamless to the individuals being served. Indeed, full integration assumes a system-wide policy that makes "any door the right door" to receive needed treatment and services. This means that people with serious mental illnesses or co-occurring disorders who are homeless must be able to enter the service system through any service door, be assessed, and have access to the full range of comprehensive services and supports they want and need (Federal Task Force on Homelessness and Severe Mental Illness, 1992).

This approach challenges the ways in which systems with different funding streams, philosophies, and missions typically offer services. However, by responding collaboratively to address the multiple needs of people who are homeless, service systems benefit from a more efficient use of limited resources. Individuals benefit from client-centered services that place the burden of coordination on the systems that are serving them (NTAC, 2000).

Barriers to Integrating Services

Despite distinct advantages to both systems and clients, the barriers to integrating service systems are both broad and deep. As one observer notes, "While everybody is in favor of coordination, nobody wants to be coordinated." (Feldman, 1976).

Some specific system-level barriers to effective integration include:

- Well-established programs and a specialized work force;
- Interagency turf battles;
- Funding limitations;
- Lack of technology and resources to support information needs;
- Lack of available services;
- Size and complexity of the service system;
- Lack of political will and mechanisms to channel public support; and
- Legislative and political opposition.

(NASMHPD and CMHS, 1999; Yessian, 1995; Rochefort and Dill, 1994; Agranoff, 1991; Feldman, 1976)

The tools to address these barriers include the key strategies and mechanisms for systems integration highlighted below. Sometimes Federal or state regulatory, statutory, or budgetary requirements must be relaxed to make it easier for agencies to collaborate with one another. However, even small changes in the way agencies relate to one another can pave the way for greater cooperation on behalf of people with serious mental illnesses or co-occurring disorders who are homeless.

KEY SYSTEMS INTEGRATION STRATEGIES AND MECHANISMS

Successful systems integration is based on all the knowledge a community has at its disposal about the population to be served. In particular, research and experience have demonstrated that services for people with serious mental illnesses or co-occurring disorders who are homeless should be recovery-focused, culturally competent, flexible and individualized, and client-centered. Further, the full array of services that individuals need must be in place or must be created. This makes it essential that individuals with mental illnesses and substance use disorders who are homeless have access to all mainstream benefits and services for which they are eligible.

For instance, the importance of making a variety of safe, affordable housing options available cannot be overstated. Without housing, services and supports cannot be effective. Finally, individuals must be supported while making transitions among services (e.g., from transitional to permanent housing) or from an institution to the community.

Each of the specific steps outlined is critical to making systems change a reality. The strategies required to carry out each step will vary depending on the local needs, resources, and community priorities; however, strategies that have proven successful in other jurisdictions offer useful guidance (Foster et al., 1998; Hoge and Howenstine, 1997; Ridgely et al., 1998).

Develop the Infrastructure for Systems Change

Choose a Change Agent

A dedicated staff person brings energy and attention to the task of systems integration. This person should be capable of providing the leadership necessary to engage key stakeholders from all service sectors. Key leadership characteristics for such a person include "vision, entrepreneurship, political astuteness, a respect for diversity, and a talent for managing complexity." (Yessian, 1995). The systems integration coordinator must be highly respected and independent of the key collaborators to avoid the impression of favoritism or an imbalance of power.

Secure Adequate Resources

Money is a necessary, though not sufficient, ingredient of systems integration. Without flexible funding or regulatory relief, systems integrators begin in a weak position (Yessian, 1995). The next chapter includes an overview of strategies to support services for people with serious mental illnesses and/or co-occurring substance use disorders who are homeless.

Build a Coalition of Key Stakeholders

Building a coalition of key stakeholders is critical to the systems change process. This group must include individuals with the authority to commit their organizations and their resources to needed changes (Agranoff, 1991). Such groups may vary in size and composition, organizational structure and process, and missions and objectives (Cocozza et al., 2000). In general, however, coalition membership should be inclusive rather than exclusive and should involve consumers and recovering persons in an active role (Kaye and Wolfe, 1995). Other important stakeholders might include:

- Executive branch leaders from state and local governments (e.g., governors, mayors);
- Agency heads from state and local departments of housing, mental health, substance use, health, Medicaid, welfare/social services, education, homeless services, transportation, labor, criminal justice, etc.;
- Health, mental health, substance abuse treatment, and homeless assistance providers;
- Faith and community-based organizations;
- People who are homeless or formerly homeless;
- Consumers and recovering persons and their families;
- Members of the business community; and
- Advocacy groups.

HHS has sponsored a series of state-level Policy Academies designed to develop the infrastructure for systems change. The Academies create or reinforce relationships among key stakeholders in selected states (e.g., the governor's office, state legislators, key program administrators, and stakeholders from the public and private sectors) who can work together to improve access to mainstream services for people who are homeless.

Nurture the Coalition and Continue to Form Partnerships

Relationships with key stakeholders must be nurtured to engage them fully in the process. Other important parties may be identified along the way and should be similarly engaged (NTAC, 2000). Once a coalition is established, members can begin to build relationships and develop a common language, define their mission, and create a structure for working together (Kaye and Wolff, 1995).

Building a coalition is a means to systems change but is not an end product. Collaborative planning is an ongoing process that involves building new relationships and securing commitment from all players to carry out a community's plan to address homelessness. When forming new or re-evaluating old relationships, individuals must be aware of preconceived notions about the services and resources of other stakeholders and be open to understanding new or different perspectives. Engaging in active listening and focusing on ideas rather than people support honest expression of ideas and information sharing (HHS, HUD, and Interagency Council on the Homeless, 1999).

Engage in Strategic Planning

Developing a formal plan for action is a critical ingredient of the collaborative planning process (HHS, HUD, and Interagency Council on the Homeless, 1999; and HomeBase, 1999; HHS, undated). This is best accomplished by strategic planning, summarized in Table 4.1. Engaging in this process helps both delineate the parameters of the systems integration effort and set specific goals and objectives. Without such a plan, systems integration efforts have no direction, no means to evaluate their progress, and no basis on which to build trust (Dennis et al., 1999).

Define the Issue

Before a community can develop a plan to integrate care for people who are homeless, it must be clear about the services it currently offers and the existing gaps or unmet needs. Data that indicate where people are not being served or are underserved in the system, along with anecdotal examples that point to barriers or gaps in the system, should be discussed openly to help the group produce a shared definition of the problem (NTAC, 2000).

Such data may include "hard" data such as admissions and clinical encounter information from programs that serve people with serious mental illnesses or co-occurring disorders and people who are homeless. "Soft" information from key informant interviews and focus groups with system stakeholders also may be considered (NTAC, 2000).

<table>
<tr><td colspan="2" style="background:black;color:white;text-align:center">Table 4.1
The Strategic Planning Process</td></tr>
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S T E P S	A C T I V I T I E S
1. Define the Issue	■ Identify existing services and resources, and gaps or unmet needs in the system. Share and discuss data to reach agreement on the definition of the problem or issue.
2. Create a Shared Vision	■ Use imagination and brainstorming to create a "preferred future." Don't be constrained by current resources.
3. Develop a Plan	■ Identify goals/objectives and strategies to achieve them. Assign responsibility for tasks to implement each strategy. Establish timeframes for completion.
4. Implement the Plan	■ Carry out selected strategies/mechanisms, as assigned.
5. Monitor Progress	■ Collect outcome data and monitor progress. Allow for ongoing input and refinement of strategies, as necessary.

Create a Shared Vision

When the group has identified the problem or problems it wants to address (e.g., lack of discharge planning for individuals with serious mental illnesses or co-occurring disorders leaving a hospital or jail), members can develop a shared vision or mission statement to create an integrated service system (National GAINS Center, 1999). When creating this vision, the group should not be constrained by the system's current configuration or resources. Rather, the vision should represent the "preferred future," or what the system could look like if integration were achieved (NTAC, 1999). Ultimately, a vision statement should be simple, concise, and clear, and should immediately engage all parties (NTAC, 2000).

Develop a Plan

When the group has defined its mission, it should develop a formal plan that specifies recommendations for change. Such a plan documents the specific goals, objectives, and strategies to make the vision a reality. For example, the group may decide that it needs to implement formal discharge planning policies to keep people with serious mental illnesses or co-occurring disorders from becoming homeless when they leave a jail, a detoxification program, or a psychiatric hospital. The plan also should assign responsibilities for tasks and set timeframes for completion (Kaye and Wolff, 1995). Procedures to measure outcomes to ensure accountability should be built in, as well.

Implement the Plan

A number of mechanisms may be used to achieve a community's specific goals, as highlighted in Table 4.2. These include co-location of services, pooled or joint funding, and streamlined application procedures. For example, a homeless services provider may station a case manager at the jail to help create discharge plans for people with serious mental illnesses and/or co-occurring substance use disorders who are at risk of homelessness.

Many of these strategies have been successful in promoting systems integration in other communities, including those involved in the ACCESS (Access to Community Care and Effective Services and Supports) demonstration program, administered by SAMHSA's Center for Mental Health Services. Findings from the ACCESS program evaluation indicate that successful implementation depends, in part, on the specific strategies selected. Certain mechanisms, such as the use of interagency agreements, appear to be easier to implement. Others, including the development of interagency management information systems or the establishment of common eligibility criteria, require time and a well-functioning infrastructure to implement successfully (Cocozza et al., 2000).

Monitor Progress

Incremental improvements as well as long-term accomplishments can be highlighted by collecting and analyzing data (NTAC, 2000). For example, a community might measure the number of days homeless after leaving jail as an indicator of successful discharge planning efforts for people with serious mental illnesses or co-occurring disorders at-risk of homelessness. This information also can be used to make mid-course corrections in the implementation plan, as necessary.

Successful evaluation efforts require the establishment of guidelines for consistent data collection, performance standards, and reporting. Quality assurance can be linked to funding (e.g., written into contracts) as a means of ensuring compliance and promoting effective practices. Strategies for evaluating outcomes are described further in Chapter 7.

Seek Technical Assistance

The value of technical assistance at critical junctures is an important strategy in a successful systems change initiative. Communities sometimes need an outside facilitator to help with the strategic planning process or an evidence-based practice expert who can advise on implementing a specific service component (Pitcoff, 1997; Dennis et al., 1999). It also may be helpful to visit and talk with others who have already implemented a similar approach or system component in another community. Being able to identify specific technical assistance needs and to seek help early in the process can help communities avoid losing the momentum needed to achieve lasting change.

Table 4.2 **Implementation Strategies**
Co-locate services—Provide multiple services in a single location for "one-stop shopping" for users.
Train and cross-train staff—Train own staff or staff from other agencies about a particular topic or agency's services.
Create interagency agreements or memoranda of understanding—Enact agreements among agencies, either formal or informal, that specify arrangements to share information and referrals or coordinate services.
Implement interagency management information systems (MIS)—Develop MIS and computerized client tracking systems that link agencies, promote information sharing, simplify referrals, and facilitate clients' access to services.
Use pooled or joint funding—Try aggregating or combining funds to create new services or resources to support interagency activities.
Develop uniform applications, eligibility criteria, and intake assessments—Create a standard process or form used by multiple agencies that an individual completes only once.
Use interagency service delivery teams—Establish interdisciplinary teams from different agencies that address the multiple needs of clients in an integrated manner.
Make some flexible funding available—Use noncategorical funding to fill gaps in services, purchase expertise, or leverage additional resources.
Consider special waivers—Apply for or implement waivers in regulatory, statutory, or budgetary requirements that reduce barriers and promote access to services.
Consolidate programs or agencies—Combine multiple agencies or programs under a central administrative structure to reduce fragmented services.

Participate in Community-Wide Planning Efforts

Systems change can't happen in a vacuum. A number of local and statewide planning processes can bring key stakeholders to come together and create a plan for services. The needs of people with serious mental illnesses and/or co-occurring substance use disorders who are homeless must be represented in these plans. In addition, these groups may have valuable data and ideas to share, and their members may include some of the key players you need on your team.

For example, the *Continuum of Care* process is more than an application for HUD Homeless Assistance funds. According to HUD, a Continuum of Care plan is "a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness." (HUD, 1999).

Mental health and substance abuse services providers must participate in Continuum of Care planning to ensure that the needs of the individuals they serve are represented in requests for homeless assistance funds. Likewise the HUD Consolidated Plan, needed to access mainstream housing resources, is a strategy for holistic community planning. State and community Consolidated Plans are built on public participation. The volume, *How to Be a "Player" in the Continuum of Care: Tools for the Mental Health Community,* is an excellent resource in this regard (Technical Assistance Collaborative, 2000).

 (Technical Assistance Collaborative, 2000).

Finally, in response to the Supreme Court's 1999 decision in *Olmstead versus L.C.*, most states have created task forces or commissions to develop plans to serve people with disabilities in less restrictive settings (GAO, 2000b). CMHS provides funds and technical assistance for statewide coalitions that are addressing barriers to full community integration for adults and children with mental illnesses. Because people with serious mental illnesses and/or co-occurring substance use disorders leaving institutions are at risk for homelessness, and those living precariously in the community are at risk for unnecessary hospitalization, key stakeholders in the mental health services, substance abuse treatment, and homeless service systems must be active players in developing statewide *Olmstead* plans.

ENSURING ADEQUATE RESOURCES

Devising a formal plan and getting the commitment of top-level leaders and key stakeholders are critical to any successful systems change effort. However, while necessary, they are not sufficient alone to make change a reality. Planning must be linked to adequate financial resources. Finding ways to leverage resources, make better use of mainstream resources, and pursue new sources of funding are essential. Improved coordination among existing funding sources also is necessary. The next chapter describes strategies to support housing and services for people with serious mental illnesses or co-occurring disorders who are homeless.

C H A P T E R

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5

Finance a Comprehensive System of Care

Financing housing and support services for people with serious mental illnesses and/or co-occurring substance use disorders who are homeless is a challenge for local providers. The public mental health and substance abuse treatment systems, as well as the system of services for people who are homeless, have multiple players. These include public and private mental health and substance abuse treatment providers, and general and specialty health care providers, as well as the social welfare, housing, criminal justice, employment, and education systems, among others. The funding streams that finance these systems and services are complex and sometimes contradictory, with competing incentives among funding sources.

To help address homelessness over the long-term, communities need to know the various sources of funding that exist and how to use them effectively.

As a result, providers of services to people who are homeless rely on a myriad of often tenuous funding sources that they describe with terms like "house of cards" and "patchwork quilt." (HRSA, 1998b). Generally, these sources include funds from the Federal government, as well as from private funders, and state and local governments (Burt et al., 1999).

To help address homelessness over the long-term, communities need to know the various sources of funding that exist and how to use them effectively. This chapter provides (1) principles for accessing and using resources to provide housing and supportive services in the community, and (2) an overview of public and private funding sources available for this purpose.

A CCESS AND U SE C OMMUNITY R ESOURCES

The fragmented nature of programs and funding makes it difficult for communities to meet the needs of people with serious mental illnesses and/or substance use disorders in an efficient and cost-effective manner (NAEH, 2000). Frequently, these individuals make use of high-cost services such as emergency rooms and inpatient care. They may be discharged to the community with no after-care plan. Further, resources for housing and support services increasingly are limited. In light of these realities, communities continually must look for new ways to use scarce resources more effectively through better integration and coordination (Glover and Gustafson, 1999), while seeking further resources to fill known service gaps.

Identify System/Service Gaps

A plan to finance housing and services should flow naturally from, and perhaps be a part of, an agency's strategic plan (McMurray-Avila, 2001). Once a community has identified its needs for housing and services and has specified the goals and strategies it will use to meet those needs, it must examine how existing housing and services resources are being used. By identifying service system gaps and the costs imposed by these gaps, communities can begin to see where existing resources can be used more effectively and where new funding may be needed.

Integrate, Coordinate, and Streamline Existing Funding

The first step to make better use of existing resources is to find ways to integrate, coordinate, and streamline existing funding (Wilkins, 2002). Top-level management of agencies that fund housing and services must commit their organizations to interagency partnerships or agreements that promote more efficient use of existing resources.

For example, two or more agencies may decide to submit joint funding applications, or to commit funds to support the creation of new services or help leverage additional resources. They also may choose to aggregate funds from multiple sources where they can do so and still meet statutory and reporting requirements attached to these funds. When communities have more effectively combined and used existing resources for housing and services, they will have a better sense of where new investment is needed to fill the remaining gaps in the service systems (McMurray-Avila, 2001).

Identify New Resources

Often, new program resources will consist of existing Federal, state, or local funds that can be targeted to better respond to locally identified needs for housing and services for people who are homeless. Categorical programs, restricted to serving only certain target populations, often can be tapped as a resource. For

example, monies designated for individuals with HIV/AIDS may serve individuals who are homeless, many of whom are at risk of, or infected with, HIV. Funds from such programs may be used to serve some but not all of those in need.

The current array of targeted homeless assistance programs is not large enough or well-funded enough to meet long-term housing and support needs of people who are homeless (NAEH, 2000). Therefore, mainstream resources—including such Federal and state resources as Medicaid, Temporary Assistance to Needy Families (TANF), the mental health and substance abuse block grants, and the Home Investment Partnerships (HOME) program—represent a critical potential source of funding for people with serious mental illnesses and/or co-occurring substance use disorders who are homeless. While many people who are homeless qualify for these programs, they often are unable to access the services that these programs offer (GAO, 2000a).

Funds from mainstream programs can be used to provide income support, housing assistance, and supportive services, including outreach, case management, and Assertive Community Treatment. Broadening eligibility criteria for a program or targeting a portion of program funds to meet the needs of people who are homeless can provide additional sources of support.

For example, a state may seek a waiver under the Medicaid program to increase the number of individuals it serves or to provide additional services targeted to vulnerable individuals. Frequently, this means creating a managed health care system that may, or may not, serve homeless people well. Coordinating mainstream resources with discretionary funds such as tax revenues, which provide support for individuals not eligible under categorical programs, can be an effective strategy to meet a community's overall housing and service needs.

Communities should explore other sources for new funding, as well. For example, a housing trust fund, established at the state or local level, can provide a dependable, flexible, and ongoing source of dedicated funding to meet the housing needs of low-income people, including those who are homeless (Brooks, 1999; AIDS Housing of Washington, 2000). Private sector resources, including foundations and businesses, also should be considered as potential sources of funding for programs and services.

Leverage Funds

Frequently, existing resources can be used to leverage new sources of funding. For example, communities may "use funds provided through existing and/or new grant programs that are targeted to homeless people to leverage matching allocations from mainstream funding and greater access to mainstream service systems" (Corporation for Supportive Housing [CSH], 2002a, p. 36). In particular, funds for supportive services may be used to leverage funds for housing, and vice versa. Forming partnerships between state and local governments, and with the private sector, can be an effective way of leveraging available funds from all sources.

FUNDING SOURCES

The balance of this chapter provides examples of public sources of funding—such as those available through the Federal government and state and local governments—as well as private sources, including business and foundations. This listing is not exhaustive; rather it provides a sampling of the major kinds of resources available. Each varies in terms of its use and requirements. Many can be combined creatively to offer a full range of housing and supports needed to end homelessness among people with serious mental illnesses and/or co-occurring substance use disorders (HRSA BPHC, 1997; Siemon, 1990).

In seeking resources to implement and sustain plans to address homelessness, communities need to consider all possible sources of funding, not just those mentioned here. While getting started often requires piecing together funds available from time-limited sources, communities should strive to find sources that are both reliable and predictable, if they are to sustain housing and supports over the long-term. Often, this means securing mainstream housing and service dollars for individuals who have been relying on categorical or time-limited funds.

Public Funding

Public funding sources for services and housing include resources specifically targeted to meet the needs of people who are homeless, as well as nontargeted, mainstream resources that may or may not include people who are homeless as a priority population. Such nontargeted programs typically are designed to serve low-income people or people with special needs more generally. Potential sources of public funding are described briefly in this section. Web sites that provide further detail on public funding sources are listed at the end of the chapter.

Targeted Homeless Assistance

Programs specifically targeted to meet the needs of people who are homeless include those originally created under the Stewart B. McKinney Homeless Assistance Act and its amendments. While many such programs were established under this Act, those most relevant to meeting the housing and support service needs of people with serious mental illnesses and/or co-occurring substance use disorders who are homeless are discussed below. These include programs administered by the Departments of Health and Human Services, Housing and Urban Development, and the Veterans Administration (GAO, 1999a).

HHS Programs. HHS administers three programs specifically designed to meet the needs of people who are homeless and who may have serious mental health and/or substance use disorders.

■ *The Health Care for the Homeless (HCH) program*, administered by the Health Resources and Services Administration, awards grants to community-based organizations—including community health centers,

local health departments, hospitals, and nonprofit community coalitions—to improve access to primary health care, mental health services, and substance abuse treatment. HCH funds support the provision of primary health care, substance abuse treatment, outreach, case management, provision of or referral to mental health services, and assistance in obtaining housing and entitlements (HRSA BPHC, 2001).

■ *The Projects for Assistance in Transition from Homelessness (PATH) program,* administered by SAMHSA's CMHS, awards formula grants to states and territories to support community-based services for people with serious mental illnesses and/or substance use disorders who are homeless or at-risk of homelessness. PATH funds can be used to support a range of services, including outreach, screening and assessment, case management, mental health services, and substance abuse treatment, provision of or linkage to supportive services, and a limited set of housing services (CMHS, 2001c).

■ *The Grants for the Benefit of Homeless Individuals (GBHI) program,* administered by SAMHSA's Center for Substance Abuse Treatment, provides funds to develop and expand mental health and substance abuse treatment services for people who are homeless. Grants are awarded to local public and nonprofit agencies to provide either substance abuse services, mental health services, or both, allowing communities the flexibility to provide the services they believe to be the most urgent (SAMHSA, 2002a).

HUD Homeless Assistance Programs. HUD administers four key targeted programs that can be used to fund the development, operation, and supportive services of emergency, transitional, and permanent housing for people who are homeless.

■ *Emergency Shelter Grants* are formula grants to states and local governments for the purpose of providing emergency and transitional housing, and are coordinated through the Consolidated Plan, a 5-year comprehensive housing plan required of communities to access HUD housing resources.

■ Supportive Housing Program (SHP), Shelter Plus Care (S+C), and Section 8 Moderate Rehabilitation Single Room Occupancy (SRO) program funds are awarded through an annual competition that requires communities to engage in a coordinated strategic planning process and to submit a comprehensive Continuum of Care plan to address homelessness. SHP funds may be used for the development and operation of transitional and permanent housing, and for supportive services. S+C funds may be used to provide rental assistance for permanent housing, with required matching funds for supportive services. Section 8 SRO funds can be used for rental assistance in single-room-occupancy dwellings.

VA Programs. The VA administers several programs that specifically meet the needs of veterans with mental illnesses and/or substance use disorders who are homeless (Department of Veterans Affairs, 2002).

- *The Domiciliary Care for Homeless Veterans program* provides funds to VA medical centers to support the delivery of health, mental health, substance abuse, and other social services in residential treatment settings for veterans who are homeless.

- *The Homeless Chronically Mentally Ill Veterans program* supports mental health services, substance abuse treatment, case management, and other rehabilitative services in community-based residential treatment settings for veterans with chronic mental illnesses who are homeless.

- *The Health Care for Homeless Veterans program* supports outreach and assessment, treatment, case management, and referral to community-based residential care for veterans with serious mental illnesses and substance use disorders who are homeless.

- *The HUD-VA Supported Housing program,* administered jointly with HUD, provides permanent supportive housing and treatment for veterans with serious mental illnesses and substance use disorders who are homeless.

Mainstream Resources

A number of nontargeted or mainstream programs serving low-income people and people with disabilities also may provide eligible individuals who are homeless with housing, services, and supports. This includes an array of health, welfare, mental health, substance use, housing, and veterans' assistance programs. Efforts to increase access to these programs for people who are homeless are essential.

HHS Programs. HHS administers a number of mainstream programs, for which homeless people may be eligible, that also can be used to provide services and supports (GAO, 1999a).

- *Medicaid* is the largest Federal entitlement program providing health care for certain low-income and medically needy people, including people who are elderly, blind and disabled, and other special groups. The program is funded jointly through a Federal-state partnership. Within Federal guidelines, each state administers its own program and sets its own criteria for eligibility, type, amount, duration and scope of services, and payment as outlined in the State Medicaid Plan. Optional services, such as the rehabilitation option and the targeted case management option, can be used to provide many of the supportive services needed to help maintain people with serious mental illnesses or co-occurring disorders in housing (CSH, 2002a).

- *Temporary Assistance to Needy Families* funds are provided to states through block grants to help low-income families become self-sufficient. States have flexibility to design programs that meet the needs of eligible populations, including homeless families with children. Cash assistance, work-related assistance, and other supportive services are included. In addition, several states and localities have recently begun innovative programs using TANF or state maintenance-of-effort funds to provide housing assistance to families making the transition from welfare to work (Straka et al., 2001; Sard and Lubell 2000).

- *Community Mental Health Services Block Grant* funds are formula grants to states and territories to create comprehensive, community-based systems of care for adults with serious mental illnesses and children with severe emotional disturbances. Funds are used at the discretion of states to provide services such as health, mental health, rehabilitation, employment, housing, and other supportive services. Most states provide services specific to adults with serious mental illnesses who are homeless. In some cases, states have used block grant funds to provide services in supportive housing (Emery, 2001). Mental health block grant funds also may be used to provide services for individuals with substance use disorders within certain guidelines (SAMHSA, 2002a).

- *Substance Abuse Prevention and Treatment Block Grants* also are formula grants to states and territories, in this case, to fund alcohol prevention and treatment activities, prevention and treatment related to other drugs, and primary prevention programs. All individuals who have alcohol or substance use problems are eligible for services, including people who are homeless, or persons with co-occurring substance use disorders.

- *Community Health Centers,* supported by discretionary project grants, provide preventive and primary care services to medically underserved populations; many have specific programs designed to serve individuals who are homeless.

- *Community Services Block Grants* are formula grants to states to support a range of services designed to address poverty and to promote self-sufficiency among low-income members of communities, including those who are homeless.

- *Social Services Block Grants,* also formula grants to states, can be used to support a range of services to prevent, reduce, and eliminate dependency and increase self-sufficiency among community residents.

Using Medicaid to Finance Supportive Services in Housing. Medicaid represents a potentially reliable source of mainstream funding to support many of the health-related services provided in supportive housing. Further, it provides opportunities for states and local communities to leverage additional Federal matching funds for services, permitting a greater portion of HUD resources to go toward permanent housing.

The Corporation for Supportive Housing (CSH) recently examined opportunities to fund services in supportive housing using Medicaid (CSH, 2002a). CSH found that while major challenges still exist, many governments and supportive housing providers have succeeded in using Medicaid to finance supportive services in housing.

For example, under Medicaid's rehabilitation option, providers can be reimbursed for services aimed at improving skills and functioning impaired by mental illnesses and, in some states, substance use disorders. The targeted case management option can be used to support goal setting and linkage to health and other social services. Through partnerships with Federally Qualified Health Centers, providers can deliver health, mental health, and substance abuse treatment services to people living in supportive housing.

Additionally, states may use Medicaid waivers to allow funds to be used in more flexible and creative ways to fund supportive services in community-based settings. While these strategies and their implementation vary from one state or community to the next, they offer promise for expanding the use of Medicaid to fund supportive services in housing.

HUD Programs. A number of HUD programs are designed to expand affordable housing opportunities for low-income people or people with disabilities, including those who are homeless (TAC, 1999).

- *Public Housing* is developed, owned, and managed by public housing agencies (PHAs) under contract with HUD. HUD provides a subsidy to cover operating and management costs of the units, and tenants generally pay 30 percent of their incomes toward rent. PHAs are allowed to establish local preferences for income targets and tenant selection and must submit a 5-year plan that outlines these preferences and demonstrates their consistency with the local needs and strategies identified in the consolidated plan.

- *The Housing Choice Voucher Program,* formerly referred to as the Section 8 program, is the largest Federal program targeted to very low-income households, including people with disabilities (TAC, 2002). Administered through state or local PHAs, the program offers four types of assistance: tenant-based rental assistance; project-based rental assistance; homeownership assistance; and down payment assistance. Tenant-based assistance is the most common form, offering subsidies that allow tenants to pay 30 percent of their income toward housing costs in a unit of their choice.

- *The Home Investment Partnerships program (HOME)* is specifically designed to expand the supply of affordable housing for low and very low-income people. Program funds are controlled through the consolidated plan and awarded via formula grant to states and local jurisdictions. Partnerships among government and nonprofit organizations and private industry are required to develop and manage safe, decent, affordable housing. Funds may be used for homeownership,

rental housing production, and tenant-based rental assistance, and are easily combined with funds from HUD's Homeless Assistance Programs.

■ *Housing Opportunities for Persons with AIDS (HOPWA)* supports the provision of both housing and services for people with Acquired Immune Deficiency Syndrome (AIDS). Funds are awarded by block grant to states and large metropolitan areas and can be used for a variety of activities, including housing information and coordination assistance; acquisition, rehabilitation, and leasing of property; rental assistance; operating costs; supportive services; and technical assistance (TAC, 1999).

■ *Community Development Block Grants (CDBG)* are formula grants to states and to "entitlement communities" (as defined by HUD) to provide decent housing and suitable living environments for moderate and low-income people. CDBG funds also are controlled through the consolidated plan and can be used for housing rehabilitation or construction, including shelters and transitional housing facilities, and for supportive services such as counseling, employment, and health care.

■ *The Section 811 Supportive Housing for Persons with Disabilities Program* awards funds competitively to community based nonprofit organizations to develop and operate supportive housing for people with disabilities. Funds may be used for new construction, rehabilitation, or acquisition; for project-based rental assistance; and for supportive services to address the health, mental health, or other needs of people with disabilities.

Other Mainstream Federal Programs. Several other nontargeted Federal programs can be used to provide services and supports to people who are homeless and have serious mental illnesses and/or co-occurring substance use disorders (National Abandoned Infants Assistance Resource Center, 1997). For example, the Social Security Administration's SSI program provides income support to low-income individuals and those with disabilities, including people with serious mental illnesses and/or co-occurring substance use disorders who are homeless. Individuals with a substance use disorder as their primary disability are not eligible for SSI or the Medicaid benefits that accompany it.

Programs administered by the U.S. Department of Labor (DOL) can be used to support job training and employment services. The VA offers various types of assistance to veterans and their dependents. The U.S. Department of Treasury's Low-Income Housing Tax Credit (LIHTC) program can be used to fund the development of new supportive housing. These and other sources of Federal funds offer possibilities for creating housing and supports in an overall system of care and should be examined by communities, as well.

State and Local Resources. State and local governments administer many of the Federal programs mentioned earlier. They can either provide services themselves or can contract with local providers to offer services with these funds.

In addition, many states and localities use their own resources for programs specifically designed to meet the housing and support service needs of people with serious mental illnesses and/or co-occurring substance use disorders who are homeless. Examples include programs, such as state tax credits, that can fund housing development, as well as programs that fund operation costs and/or supportive services.

Private Funding

Though public funding is crucial to providing the housing and supports needed to end homelessness, it only can go so far. Private-sector contributions, such as those from local businesses, corporations, private donors, and foundations, can be critical sources of funding, as well (The Foundation Center, 2000; McCambridge et al., 1992). Most private funding, however, is time-limited. While it cannot substitute for more secure, long-term commitments, it can be used to leverage or match other resources.

Often, foundations invest in new and untested, but promising, practices. These funds may be used to leverage public funding to help sustain programs over the long-term. In addition, some private funders are willing to invest in building the capacity of organizations, to help them diversify funding and tap into sources to sustain the funder's initial investment.

Competition for private funds is growing as more and more organizations recognize the need to fundraise from private sources, particularly for affordable housing development. Finding donors whose mission is compatible with the goal of addressing homelessness; building relationships with representatives of corporations, foundations, and other potential donors; and being able to market and submit a strong proposal for funding are all essential to obtaining private support.

F OR M ORE I NFORMATION

As noted, the public sources of funding listed in this chapter represent a sampling of the major kinds of resources that are available to fund services and housing for people who are homeless and have serious mental illnesses and/or co-occurring substance use disorders. The following web sites include more information on Federal funding opportunities, including discretionary funding for homeless services available through SAMHSA:

U.S. Department of Health and Human Services (HHS)

www.hhs.gov

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.samhsa.gov

Health Resources and Services Administration

www.hrsa.gov

Centers for Medicaid and Medicare Services

www.cms.gov

U.S. Department of Housing and Urban Development (HUD)

www.hud.gov

U.S. Department of Veteran's Affairs (VA)

www.va.gov

U.S. Social Security Administration

www.ssa.gov

PUTTING THE PIECES TOGETHER

An integrated, well-financed system of care for people with serious mental illnesses and/or co-occurring substance use disorders who are homeless is only as good as the services it offers. Further, the services will be of little use if they are not accessible, acceptable and of personal value to the people they are designed to serve.

The next chapter comprises Section III: Organize Services. It features an in-depth discussion of evidence-based and promising practices for people with serious mental illnesses and/or co-occurring substance use disorders who are homeless.

ORGANIZE SERVICES

Planning is the first critical step in developing an integrated, comprehensive

system of care for people with serious mental illnesses and/or co-occurring

substance use disorders who are homeless. When the planning is done, the real

work begins. The good news is that communities and providers don't have to

reinvent the wheel. There is a wealth of information about the programs and

services that are most effective for people with serious mental illnesses and/or co-

occurring substance use disorders who are homeless.

The next chapter—Use Evidence-Based and Promising Practices—can help select
the most appropriate services for clients based on research evidence and provider
experience, including how to:

- Adopt or adapt evidence-based practices;
- Offer a comprehensive set of essential services; and
- Make use of Federal resources, including toolkits, Treatment Improvement
  Protocols, and Community Action Grant and Targeted Capacity Expansion
  grants.

Additional information on the materials cited in this chapter can be found in the
References. Organizations that offer technical assistance in these areas are listed in
the Resources section.

C H A P T E R

■ **6**

Use Evidence-Based and Promising Practices

The good news about service provision for people with serious mental illnesses

and/or co-occurring substance use disorders who are homeless can be summed

up simply: We know what works. *Now we need to put what we know to work.*

This is not to say that the work is done, however. On the contrary, there is a need for continued research into effective interventions for groups with specific needs, such as trauma survivors, and for individuals with severe disorders.

However, evidence-based and promising practices can be used immediately to help prevent and end homelessness for people with serious mental illnesses and/or co-occurring substance use disorders. SAMHSA plays a key role in getting information about evidence-based practices into the hands of the people who deliver services.

This chapter examines (1) a range of evidence-based and promising practices that have proven effective to prevent and end homelessness among people with serious mental illnesses and/or co-occurring substance use disorders, and (2) additional needed service system components of a comprehensive service system. The full array of services and supports essential to address homelessness among people with serious mental illnesses and/or co-occurring substance use disorders are summarized in Table 6.1 on page 80.

Evidence-based and promising practices can be used immediately to help prevent and end homelessness.

E V I D E N C E - B A S E D   A N D   P R O M I S I N G   P R A C T I C E S

Federal research and demonstration programs and the experience of hundreds of community-based providers have shown that the services described here help decrease symptoms of mental illnesses and substance use, and increase residential stability for people with serious mental illnesses or co-occurring disorders who are homeless. Communities can adopt or adapt these practices to local needs.

Outreach and Engagement

Compared to people with serious mental illnesses and/or co-occurring substance use disorders who are housed, individuals who also are homeless are likely to be more severely impaired, to have more basic service needs, and to be unwilling or unable to seek treatment (Federal Task Force on Homelessness and Severe Mental Illness, 1992). If they won't seek help, help has to go to them.

Once considered a nontraditional service, outreach now is recognized as the initial, most critical step in connecting or reconnecting a person who is homeless to needed health, mental health, substance abuse, and social services and to housing. However, people who are homeless are not focused initially on receiving mental health or substance abuse treatment. Outreach workers must meet them "on their own terms and on their own turf" (Federal Task Force on Homelessness and Severe Mental Illness, 1992). Outreach workers find people on the streets, under bridges, in parks, and in shelters, and they focus on meeting the individual's immediate needs for food, clothing, and shelter.

This process of engagement is essential to develop the trust and rapport needed to help individuals accept more long-term services, the ultimate goal of outreach efforts. Regardless of how or where outreach is provided, successful outreach workers must adopt a nonthreatening approach; must be flexible in the number and types of services offered, as well as the manner in which they are provided; and must make numerous contacts over extended periods of time (Interagency Council on the Homeless, 1991; McMurray-Avila, 1997). Outreach workers who have been homeless and are recovering from mental illnesses and/or co-occurring substance use disorders may be especially effective at engaging individuals who are difficult to reach (Van Tosh, 1993; Dixon et al., 1994).

What the Research Says. *Outreach, whether in shelters or on the streets, is effective* (CMHS, 2001c; Lam and Rosenheck, 1999; Tsemberis and Elfenbein, 1999; Morse et al., 1996; Bybee et al., 1995). Given the opportunity, most people with serious mental illnesses and/or co-occurring substance use disorders who are homeless are willing to accept treatment and services voluntarily. Indeed, skilled outreach teams eliminate the need for involuntary treatment for most individuals. A study of individuals enrolled in the SAMHSA Access to Community Care and Effective Services and Supports program who were contacted through street outreach revealed that even individuals with the most severe disorders, who are the most reluctant to accept treatment, will enroll in services and show improved outcomes when served by an outreach team (Lam and Rosenheck, 1999).

A study of the effectiveness of outreach with homeless people who abuse substances found that nearly half of persons contacted through outreach became enrolled in services (Tommasello et al., 1999). More important, those contacted through outreach had significantly higher levels of substance use than walk-in clients, and were more likely to be engaged in HIV risk behaviors. This indicates that outreach can be successful in reaching individuals most in need of services.

Consistent, caring, personal relationships, and the introduction of services at the client's pace are critical elements in outreach efforts designed to engage people

who are homeless into treatment. Unfortunately, few health insurance programs consider outreach a reimbursable expense. Outreach is the most common service offered by providers who receive SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) funds; for more than one-third of these providers, PATH funds are their only source of outreach revenues.

Housing with Appropriate Supports

People without homes need housing; that goes without saying. Yet, to match housing to an individual's needs, several factors are at work. For example, housing for people with serious mental illnesses historically has been in some type of congregate setting such as a group home, but preference studies show that people with serious mental illnesses want to live in integrated, regular housing rather than in segregated, mental health programs (Carling et al., 1987; Brown et al., 1991).

Initially, some individuals, especially those with substance use disorders, may require a type of low-demand housing, such as a Safe Haven, to help them re-engage in services (see the section on Low-Demand Services in this chapter for more information about Safe Havens). Indeed, while the provision of housing increases retention in substance abuse treatment for people who are homeless, individuals do less well when high-intensity services are required as a condition of housing (Orwin et al., 1999, p. 45). Ultimately, people with substance use disorders need safe housing with the appropriate level of support to help them maintain their treatment gains.

Second, housing is necessary but not sufficient to help individuals with serious mental illnesses and/or co-occurring substance use disorders who have been homeless regain psychiatric and residential stability and maintain sobriety. They require unique, flexible supportive services that are not a requirement to maintain housing. The Corporation for Supportive Housing defines these services as those (1) designed to maximize independence; (2) flexible and responsive to individual needs; (3) available when needed; and (4) accessible where the individual lives (CSH, 1996).

What the Research Says. *Providing supportive services to people in housing is effective in achieving residential stability, improving mental health and recovery from substance abuse, and reducing the costs of homelessness to the community* (Culhane et al., 2001; Lipton et al. , 2000; Tsemberis and Eisenberg, 2000; Rosenheck et al., 1998; Shern et al., 1997; Goldfinger and Schutt, 1996; Hurlburt et al., 1996). Recent studies indicate that supportive housing may be cost-effective, as well (Culhane et al., 2002; Houghton, 2001).

Most people with serious mental illnesses who are homeless prefer supportive housing, and they do well, despite widely held assumptions about the need for more structured housing for people with the most severe disorders. In fact, many people can move directly from homelessness to independent housing with supports. However, the transition from homelessness to housing is a critical time requiring intensive support and attention. Many individuals who have lived on

the streets feel isolated and disoriented when they begin living inside; services may have to be increased, rather than decreased, at this time (Susser et al., 1997).

Finally, research also reveals that consumer choice in housing is critical for success and that housing subsidies are a key component to making housing affordable for this group. However, as noted previously, subsidies do not guarantee that housing will be available.

Cost Studies

A study that tracked 4,679 homeless people with mental illnesses placed into service-enriched housing in New York City found reductions in housing and service costs compared to a control group of homeless people with similar characteristics who were not placed into service-enriched housing. The housing was created as part of the 1990 New York/New York Agreement to House Homeless Mentally Ill Individuals, a joint initiative between New York City and New York State that created and continues to maintain 3,615 units of affordable housing supported with clinical and social services (Houghton, 2001).

Researchers (Culhane et al., 2002) found that people placed in supportive housing had marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated. Before placement in supportive housing, homeless people with serious mental illnesses used about $40,451 per person, per year in services (1999 dollars). Placement in supportive housing was associated with a reduction in services use of $16,281 per housing unit per year (Culhane et al., 2002). Much of the savings resulted from fewer and shorter stays in state psychiatric hospitals, as well as decreased shelter use.

Results from the Connecticut Supportive Housing Demonstration Program, conducted from 1993 to 1998, are similar. Researchers found that supportive housing created positive outcomes for tenants while decreasing their use of acute health services and increasing their use of less expensive ongoing and preventive health care (CSH, 2002a). Also, property values in the neighborhoods surrounding the supportive housing have increased or remained steady since the housing was developed.

Multidisciplinary Treatment Teams/Intensive Case Management

People with serious mental illnesses and/or co-occurring substance use disorders who are homeless have complex problems that require comprehensive treatment and services. A multidisciplinary treatment team provides individuals with a type of "one-stop shopping" to arrange for or provide all of the services they require.

Assertive Community Treatment (ACT) is a good example of this approach. Begun in the late 1970s with the Program of Assertive Community Treatment in Madison, Wisconsin, ACT is acknowledged as a successful approach to providing a full range of community-based services to people with serious mental illnesses and/or co-occurring substance use disorders. ACT teams feature a

multidisciplinary group of mental health, substance use, and social service specialists who provide, or arrange for, each individual's clinical, housing, and rehabilitation needs. Client/staff ratios are low (typically 10 to 1), and services are available around the clock.

The ACT model has been modified successfully to meet the needs of people who are homeless. For example, because some people who have been homeless have trouble forming trusting relationships, they may be assigned to one or two members of the team, rather than the whole team. All team members are knowledgeable about each client, however (Dixon et al., 1995). Many ACT teams use mobile outreach to serve people who are unwilling or unable to come to them.

What the Research Says. *ACT and similar models of intensive case management reduce inpatient hospitalization, decrease substance use and symptoms of mental illnesses, and increase community tenure for people with serious mental illnesses and/or co-occurring substance use disorders who are homeless*. Regular assertive outreach, lower caseloads, and the multidisciplinary nature of the services available on these teams lead to positive treatment and housing outcomes (Ziguras and Stuart, 2000; Morse, 1999; Lehman et al., 1997; Morse et al., 1997; Burns and Santos, 1995; Dixon et al., 1995).

The provision of substance abuse services on an ACT team is a critical ingredient of success. Research indicates that ACT is not effective in reducing substance use when the substance abuse services are brokered to other providers and are not provided directly by the ACT team (Morse et al., 1997).

Integrated Treatment for Co-Occurring Serious Mental illnesses and Substance Use Disorders

Mental health and substance abuse providers frequently cite the problem of co-occurring serious mental illnesses and substance use disorders as the most difficult situation they face. Individuals with co-occurring disorders tend to be more symptomatic, to have other multiple health and social problems, and to require more costly care (NASMHPD and NASADAD, 1999). They are at risk for homelessness and incarceration. Among people with serious mental illnesses who are homeless, approximately half have a co-occurring substance use disorder (SAMHSA, 2002b).

Providers struggle to fund and develop effective approaches to treat people with co-occurring disorders who are homeless. Three common approaches are:

- **Sequential approach.** The individual receives treatment first for one disorder and then for the other, with treatment provided by two different agencies.
- **Parallel approach.** Two different providers, one offering mental health services and the other providing substance abuse treatment, treat the individual simultaneously. However, treatment plans rarely are coordinated.

- **Integrated services approach.** The individual participates in concurrent and coordinated clinical treatment of both mental illnesses and substance use disorders provided by the same clinician or treatment team, often in a single agency. Unfortunately, such programs are rare.

What the Research Says. *An integrated approach is superior to a parallel or a sequential approach to treatment for people who have co-occurring serious mental illnesses and substance use disorders*. Integrated treatment reduces alcohol and drug use, homelessness, and the severity of mental health symptoms (CMHS and CSAT, 2000a; Drake et al., 1998; Drake et al., 1997). Though people with co-occurring disorders who are homeless drop out of treatment programs in high numbers, the SAMHSA's Collaborative Demonstration Program for Homeless Individuals had retention rates as high as 74 percent in its programs that offered integrated treatment. Individuals did best when their treatment was combined with other services such as housing, legal services, and income support. Further research is needed to confirm the effectiveness of this approach for people with less severe disorders.

Motivational Interventions/Stages of Change

Many homeless individuals with substance use disorders are not ready for abstinence-oriented programs (Oakley and Dennis, 1996). Further, they also may lack the motivation to engage in active treatment. Motivational interventions that emerged in the substance use field (Miller and Rollnick, 1991) have been adapted for people with serious mental illnesses and/or co-occurring disorders, as well as for people who are homeless.

Motivational interventions include a range of clinical strategies designed to enhance motivation for change, including counseling, assessment, multiple sessions, and brief interventions. The five key principles of motivational enhancement are (Swanson et al., 1999; CSAT, in press):

- Express empathy;
- Note discrepancies between current and desired behavior;
- Avoid argumentation;
- Refrain from directly confronting resistance; and
- Encourage the individual's belief that he or she has the ability to change.

Further, motivational enhancement techniques must be matched to the client's stage of recovery and often are integrated as part of the Stages of Change Model (Prochaska and DiClemente, 1992). This model describes predictable stages of change for people with substance use disorders from *precontemplation* to *contemplation, determination, action, maintenance*, and *relapse prevention*.

What the Research Says. *Research has demonstrated that motivational enhancement techniques are associated with greater participation in treatment and positive treatment outcomes*. These outcomes include reductions in consumption, increased abstinence rates, better social adjustment, and successful referrals to treatment (Landry, 1996; Miller et al., 1995). A positive attitude toward change and a commitment to change also are associated with positive

treatment outcomes (Miller and Tonigan, 1996; Prochaska and DiClemente, 1992).

Modified Therapeutic Communities

Therapeutic communities (TCs) have been implemented as a method to address substance use disorders for more than 30 years. The concept is based on a clearly defined theoretical model that views drug abuse as a disorder of the whole person, requiring a focus on conduct, attitudes, moods, values, and emotional management. The community is the therapeutic method in a TC.

Modified therapeutic communities (MTCs) adapt the principles and methods of the TC to the needs of individuals with co-occurring mental illnesses, as well as the needs of those who are homeless. Key modifications for people with co-occurring disorders include increased flexibility, decreased intensity, and greater individualization (Sacks, 2000). MTCs for people who are homeless, often developed in shelter settings, incorporate services to address clients' multiple needs, such as education, vocation, legal, and housing placement services (Zerger, 2002).

What the Research Says. *Recent studies of the MTC approach reveal significant decreases in drug use and criminal activity, and increases in psychological functioning and employment* (DeLeon, 2000; Rahav et al., 1995; Sacks et al., 2001). MTCs tend to result in more positive outcomes for individuals with the most severe mental illnesses and for those who remain in treatment for longer periods of time (Zerger, 2002). Several studies have found MTCs to be cost-effective relative to the provision of services as usual (French et al., 1999; McGeary et al., 2000).

Self-Help Programs

Self-help programs represent a central feature of most substance abuse treatment plans and recently also have become an important source of support for individuals with mental illnesses. During the past decade, dual recovery/self-help programs also have emerged as an important adjunct to treatment for people in recovery from co-occurring mental illnesses and substance use disorders (Dupont, 1994; Pepper and Ryglewicz, 1996).

Self-help approaches have their roots in Alcoholics Anonymous (AA) and have grown to address a wide variety of addictions. Narcotics Anonymous and Cocaine Anonymous are two of the largest self-help organizations in the area of chemical addictions (CSAT, in press). Recovery Anonymous and Schizophrenics Anonymous support individuals with mental illnesses (Chamberlin and Rogers, 1990).

Self-help programs typically include the AA 12-step method, with a focus on developing personal responsibility within the context of peer support. However, specific applications vary according to the needs and orientation of individuals and agencies/communities. Secular groups emphasize individual empowerment

without focusing on the spirituality of the 12-step approach. Perhaps because of their low cost, and the fact that they provide an important source of support, self-help programs are among the most commonly used outpatient services for people with substance use disorders who are homeless (Zerger, 2002).

What the Research Says. *Self-help program participation decreases inpatient treatment and substance use and increases self-esteem for people with mental illnesses and substance use disorders*. Individuals with mental illnesses in self-help groups report greater-self esteem, fewer hospitalizations, and better community adjustment (HHS, 1999). People with co-occurring mental illnesses and substance use disorders who are homeless experience a greater decrease in substance use when they have a high level of self-help group participation (Gonzalez and Rosenheck, 2002).

Self-help groups specific to co-occurring disorders can be an important adjunct to recovery for people who have both mental illnesses and substance use disorders. One study found that people with higher levels of support and greater participation in dual recovery programs reported less substance use and mental health distress and higher levels of well-being (Laudet et al., 2000). However, these results did not hold true for people with co-occurring disorders who participated in the more traditional single-focus, self-help groups.

Involvement of Consumers and Recovering Persons

Individuals recovering from serious mental illnesses and/or co-occurring substance use disorders play an increasingly important role in helping their peers recover. Indeed, the social model approach to recovery from substance use disorders is built on the belief that individuals in recovery can help each other as much, if not more, than professional staff can help them. People with serious mental illnesses and/or co-occurring substance use disorders who have been homeless may be especially effective in reaching their peers who are reluctant to seek help. Shared experiences between prospective clients and workers may ease the engagement process.

Some unique characteristics of staff in recovery and those who have been homeless include: their knowledge of the service system; their "street smarts"; their ability to develop alternative approaches; their flexibility, creativity, and patience; their understanding of an individual's basic needs and preferences; and their ability to build rapport with people who are homeless. Consumers and recovering persons serve as positive role models, are a major force in the elimination of stigma and discrimination, and make good team members (Van Tosh, 1993).

Programs run by consumers and recovering persons—including drop-in centers, recovery support programs, case management programs, outreach programs, businesses, employment and housing programs, and crisis services—may be more "user-friendly" for people who are homeless or at risk of homelessness. The focus of service delivery in these organizations is on choice, dignity, and respect (Glasser, 1999). Further, such programs provide meaningful work for

consumers and recovering persons. Staff in recovery from mental illnesses and substance use disorders, and those who have been homeless, also enhance the sensitivity of the system to the needs of their peers.

Finally, consumers and recovering persons should be involved actively in the design, implementation, and evaluation of community mental health and substance abuse services. They make valuable members of planning councils and advisory boards. People who were homeless can make equally important contributions to the development of services for people who currently are homeless.

What the Research Says. *Consumers and recovering persons can make a unique and valuable contribution as program and agency staff.* In particular, consumers and recovering persons have experiences and characteristics that enhance their ability to provide services to individuals who are homeless (Glasser, 1999; Van Tosh, 1993; Dixon et al., 1994). Programs must be prepared to support staff in recovery with adequate supervision and workplace accommodations, if necessary, and to educate and train other staff about employment for consumers and recovering persons (Van Tosh, 1993; Fisk et al., 2000).

Prevention Services

Services that prevent people with serious mental illnesses and substance use disorders from becoming homeless in the first place should be a critical component of a community's plan to end homelessness. In its report, *Outcasts on Main Street*, the Federal Task Force on Homelessness and Severe Mental Illness called prevention efforts both humane and cost-effective (Federal Task Force on Homelessness and Mental Illness, 1992). Two years later, with publication of *Priority: Home! The Federal Plan to Break the Cycle of Homelessness*, the Interagency Council on Homelessness proposed a two-pronged approach to address homelessness: (1) expanding services to help those who have become homeless, and (2) addressing structural inadequacies in housing and social services to help prevent people from becoming homeless (Interagency Council on the Homeless, 1994).

Strategies designed to prevent homelessness among people with serious mental illnesses and/or co-occurring substance use disorders must be designed to *reduce risk factors*, such as lack of treatment for co-occurring disorders, which make individuals more susceptible to becoming homeless. Many of these risk factors have been discussed elsewhere in this report. Further, program planners and providers must work to *enhance protective factors*, such as supportive services in housing, that will mitigate against homelessness among vulnerable people (Lezak and Edgar, 1998).

What the Research Says. *Homelessness among people with serious mental illnesses and/or co-occurring substance use disorders can be prevented.* Discharge planning, sometimes referred to as re-entry or transition planning, is one effective prevention strategy. Providing short-term intensive support

services immediately after discharge from hospitals, jails, or residential treatment has proven effective in preventing recurrent homelessness during the transition to other community providers (Rosenheck and Dennis, 2001; Shinn and Baumohl, 1999; Lezak and Edgar, 1998; Averyt et al., 1997; Susser et al., 1997).

Effective discharge planning should begin when an individual *enters* a hospital or jail. Elements of the discharge plan, which should be developed with the individual and should be culturally appropriate, include housing, health care, treatment, income, employment, entitlements, personal support, and life skills training (Rosenheck and Dennis, 2001; Shinn and Baumohl, 1999; Lezak and Edgar, 1998; Avery et al., 1997; Susser et al., 1997).

In addition to discharge planning, studies show that subsidized housing helps prevent homelessness, even for people with serious mental illnesses and/or co-occurring substance use disorders. Income support also is critical, since housing affordability is a function of both income and housing costs (Shinn and Baumohl, 1999).

OTHER ESSENTIAL SERVICES

Housing, treatment, and support services are the backbone of a comprehensive system of care for people with serious mental illnesses and/or co-occurring substance use disorders who are homeless or at risk of becoming homeless. But these evidence-based and promising practices must be offered as part of a full range of services that are appropriate, accessible, and acceptable to consumers and recovering persons.

The hallmarks of these services are *outreach, choice, and ongoing support*. Some of the services, such as psychosocial rehabilitation and supported employment, were designed for people with serious mental illnesses and have been adapted for individuals who are homeless. Other programs that were designed for people who are homeless also serve people who have serious mental illnesses and/or co-occurring substance use disorders. All of these efforts help prevent or end homelessness.

Primary Health Care

As noted previously, people with serious mental illnesses and/or co-occurring substance use disorders who are homeless are at risk for both minor and life-threatening diseases, including diabetes, liver disease, tuberculosis, Hepatitis B and C, and HIV/AIDS. Life on the streets makes it difficult to receive appropriate care.

Because of their low incomes, the high cost of health care, and inadequate or nonexistent private health insurance, most people with serious mental illnesses rely on Medicaid, Medicare, and other government programs to provide mental health services, medications, and general medical care. People with substance

use as their primary disorder are ineligible for SSI and Medicaid, which increases their risk of homelessness and makes it especially difficult for them to get medical care once they become homeless.

Further, people with serious mental illnesses who become homeless may be unable to enroll in these programs or continue to receive their benefits. Complicated eligibility requirements, lack of a permanent address, and untreated mental illnesses and substance use disorders make it difficult for individuals to obtain and maintain the benefits to which they are entitled (GAO, 2000a; CHSF, 2003). As a result, they frequently use such high-cost services as emergency room and inpatient care. When they present in emergency rooms, they are at increased risk for hospitalization, where their medical conditions may prolong their stay. Their debilitated condition also makes them more vulnerable to attack on the street or in drop-in shelters (Fischer, 1992).

Special health care programs designed for people who are homeless feature outreach and intensive case management to address an individual's full range of needs. These include the Health Care for the Homeless (HCH) program, administered by the HRSA's Bureau of Primary Health Care in HHS.

HCH projects, many of which serve individuals who have serious mental illnesses and/or co-occurring substance use disorders, are designed to be comprehensive, accessible, and culturally competent in an effort to help patients exit homelessness (McMurray-Avila, 1997). Many of these programs use mobile, interdisciplinary treatment teams to reach people on the streets or in shelters rather than requiring facility-based care.

Trauma-Sensitive Services

Health care providers working with people who are homeless must screen for and address trauma, including past and ongoing physical and sexual abuse. Individuals unable or unwilling to speak about the trauma they have experienced may present with somatic disorders such as headaches and backaches. Untreated trauma may complicate the treatment for mental illnesses and substance use disorders, leaving individuals at risk for recurrent homelessness.

Alcohol and Drug Abuse Services

The goal of substance abuse treatment for people who are homeless is to prevent, deter, or eliminate substance use and addictive behaviors. Treatment services may include outreach, counseling and education, case management, day programs, detoxification, and self-help and peer support activities (McMurray-Avila, 2001). These services may be provided in outpatient settings and alternative living arrangements, such as residential treatment settings and community-based halfway houses.

Substance abuse treatment is particularly critical for individuals with co-occurring mental illnesses. A recent study revealed that among homeless clients with co-occurring disorders, those who reported extensive participation in substance abuse treatment showed clinical improvement comparable to or better

than individuals without co-occurring disorders (Gonzalez and Rosenheck, 2002).

Mental Health and Counseling Services

People who are homeless must have access to a full range of outpatient and residential mental health services, including crisis interventions, individual supportive therapy, family or group therapy, medication management, and therapeutic approaches that address multiple problems. As noted previously, access to coordinated treatment for co-occurring mental illnesses and substance use disorders also is necessary and superior to other approaches for reducing alcohol and drug use, homelessness, and the severity of mental symptoms among people with co-occurring disorders (Carey, 1996; Drake et al., 1998).

The use of medications within specific parameters is an evidence-based practice for people with serious mental illnesses. Guidelines for the use of medication are being established and evaluated, but there are a number of promising practices that can, and should, be adapted to individuals with serious mental illnesses, including those who are homeless. For example, many people with serious mental illnesses have benefited from a new generation of antipsychotic medications, sometimes called "atypical" drugs. Because these new drugs generally produce fewer side effects, individuals are more likely to continue to take them (HHS, 1999).

Concern about cost and treatment approaches that require patients to "fail" on older medications first may keep some individuals from receiving these potentially beneficial drugs. In response, some states, such as Massachusetts and Texas, have issued guidelines about the use of the new generation medications. The Texas Medication Algorithm Project (TMAP) recommends the use of all of the atypical or novel antipsychotics, other than clozapine, for the initial treatment of schizophrenia (Mellman et al., 2001).

Treatment for people with mental illnesses and/or co-occurring substance use disorders is complicated by the interactive effects of psychoactive medications and illicit drugs or alcohol, as well as by the effects of prescribed psychoactive medications on people who have substance use disorders (SAMHSA, 2002b). In addition, clinicians need to be aware that different racial and ethnic groups, as well as women and men, respond differently to psychiatric medications. For example, many Asians and Hispanics with schizophrenia may require lower doses of antipsychotics than Caucasians to achieve the same blood levels (HHS, 1999).

Psychosocial Rehabilitation

The terms "psychosocial rehabilitation" and "psychiatric rehabilitation" often are used synonymously and interchangeably. Typically, psychosocial rehabilitation refers to a range of services, exclusive of clinical treatment, designed to help individuals with serious mental illnesses recover functioning and integrate or re-integrate into their communities. Psychosocial rehabilitation programs may or

may not include the specific technology of psychiatric rehabilitation (P. Kramer, personal communication, December 3, 2001).

Psychiatric rehabilitation, as defined and developed by the Boston Center for Psychiatric Rehabilitation, is a specific, well-tested approach to helping people with serious mental illnesses function with success and satisfaction in environments of their choice with the least amount of professional intervention possible (Anthony et al., 1990). According to the philosophy of psychiatric rehabilitation, *recovering is what people with psychiatric disabilities do; psychiatric rehabilitation is what helpers do to encourage the recovery process* (Anthony, 1993).

Because psychiatric rehabilitation is an approach and not a program model, it can be applied in a variety of settings or programs, including case management and vocational programs that serve people who are homeless. Typically, such programs focus on independent living and social skills training, psychological support for individuals and their families, housing, vocational rehabilitation, social support, and access to leisure activities. Psychiatric rehabilitation programs that serve people who are homeless may have an added emphasis on outreach and on building trusting relationships that will allow individuals to explore their choices and learn the skills they need to succeed.

Randomized clinical trials have shown that participants in psychiatric rehabilitation programs have fewer and shorter hospital stays and are more likely to be employed (HHS, 1999). The emphasis on choice, on individual potential, and on real-world settings may be especially attractive to people with serious mental illnesses who are homeless and who have had prior negative experiences with professionally directed treatment programs. Indeed, studies of the use of psychiatric rehabilitation with people who are homeless indicate this approach successfully engages disaffiliated individuals, expands their use of human services, and improves their housing conditions, mental health status, and quality of life (Shern et al., 2000).

Income Support and Entitlement Assistance

People who are homeless need adequate income to help them secure and maintain housing. With limited work histories, they frequently must rely on Federal income and entitlement programs, including SSI. But many are not enrolled. Outreach to people with serious mental illnesses, especially those who are homeless, is essential to help them negotiate the benefits application, eligibility, and appeals process. The goals of outreach include (Bianco and Milstrey-Wells, 2001):

- Providing accurate information about disability benefits and work incentive programs;
- Helping individuals gather the required personal, financial, and medical documentation or referring them to programs that provide this assistance; and
- Helping individuals file an application and mount an appeal, if necessary.

In response to the need for knowledgeable advocates to help individuals navigate complex program requirements, the Social Security Administration (SSA) established the Benefits Planning, Assistance, and Outreach program, authorized to fund community-based outreach projects in every State. Outreach providers, trained by SSA, are knowledgeable about other Federal benefit programs, as well, such as the TANF, Medicaid, and HUD programs.

Knowledgeable case managers (including peer case managers) and clinicians can make an enormous difference in their clients' ability to obtain and maintain disability benefits. With the client's approval, case managers may request duplicate copies of SSA mailings, especially helpful for individuals who have difficulty understanding their responsibilities and responding in a timely manner.

Case managers also may serve as representative payees for clients who need help managing their benefit checks, or who fear that checks sent to shelter addresses will be stolen. About 25 percent of individuals who receive SSI have a representative payee.

Employment, Education, and Training

People with serious mental illnesses and substance use disorders, including those with histories of homelessness, want and need to work. For many, work helps them recover from their disabilities. Further, income from work may help individuals regain and maintain residential stability (Shaheen et al., 2001). Adequate standards of living and employment are associated with better clinical outcomes.

The same factors that place people with serious mental illnesses at increased risk of homelessness are challenges to obtaining and retaining employment (Lezak and Edgar, 1998). These include symptoms of their illness, lack of housing, stigma and discrimination, and co-occurring substance use disorders. Likewise, people with substance use disorders exhibit behaviors that often interfere with job success.

Therefore, people who are homeless need more services and support than traditional job training programs offer. Successful job training programs for people who are homeless include comprehensive assessment, ongoing case management, housing, supportive services, job training, job placement services, and followup (Northern Illinois University, 1991).

Employment program models effective for people with serious mental illnesses, including transitional employment, supported employment (an evidence-based practice), and individual placement and support, must be flexible in how they define success and be prepared to work with individuals who are homeless over the long-term. A "work-first approach," as opposed to extensive pre-vocational training, can motivate a person who is homeless to address other problems in his or her life. Thus, employment programs must strike a balance between requiring complete abstinence or freedom from symptoms and tolerating some substance

use-related behaviors or symptoms of mental illnesses on the job (Shaheen et al, 2001).

Because mental illnesses often emerge in late adolescence or early adulthood, education and career plans may be interrupted. Individuals re-entering school have similar support needs to people adjusting to a competitive work environment, including a full range of housing, health and mental health, and support services (Shaheen et al, 2001).

Services for Women

Gender-specific programs have been shown to improve retention and outcomes for women in substance abuse treatment (Zerger, 2002). For example, a Los Angeles study that examined women treated in publicly funded residential drug treatment programs found that participants in women-only programs had more problems at program outset, but they spent more time in treatment and were twice as likely to complete treatment compared to women in mixed-gender programs (Grella, 1999).

Too often, however, treatment is geared to men and conducted with scant attention to women's needs. For instance, women often dislike the confrontational approach common to substance abuse treatment. Further, the specific needs of mothers with children often are not met in existing treatment programs. In particular, research on homeless mothers with substance use disorders indicates that the lack of childcare is a significant barrier for many women seeking treatment (Zerger, 2002).

Because physical and sexual abuse are so common among women who are homeless and those who have mental illnesses and substance use disorders, programs designed for women must include an active program of trauma recovery (Harris, 1996). Women who have become homeless after fleeing a dangerous household need specialized residential assistance.

Low-Demand Services

As noted elsewhere in this report, individuals with serious mental illnesses and/or co-occurring substance use disorders who are homeless initially may be reluctant to engage in services. They may have had negative experiences with the behavioral health care system, lack the motivation to begin treatment, or be more concerned about their immediate needs for food, shelter, and income.

Experience has shown that flexible, low-demand services may accommodate individuals who initially are unwilling to commit to more extended care. The ultimate goal of such services is to increase an individual's motivation for treatment and engage them in more intensive services (Zerger, 2002; McMurray-Avila, 2001). The need for such services was a major finding of the NIAAA Cooperative Agreement Program (NIAAA, 1992).

HUD recognized the need for low-demand services when it established its Safe Havens program for people who are homeless and have serious mental illnesses. Safe Havens are a type of supportive housing that serve individuals who, perhaps because of their illness, have refused help or have been denied or removed from other programs serving people who are homeless. Individuals are not required to participate in treatment but, as they are ready, are expected to re-engage in services and move to permanent housing with supports.

For individuals with substance use disorders, a sobering station is a low-demand setting that accepts people who are intoxicated and serves as a first point of contact with the human services system (Baumohl and Huebner, 1991). Likewise, the presence of chemical dependency staff in a shelter or drop-in center may introduce individuals to the availability of substance abuse treatment (Zerger, 2002).

Crisis Care Services

People with serious mental illnesses are in danger of becoming homeless when a crisis occurs, including exacerbation of symptoms, other medical emergencies, family stress, or the loss of a benefit check or employment. This is especially true for people with co-occurring substance use disorders. Providers must recognize the importance of being able to respond quickly to people in crisis, help them on-site if needed, and provide short-term crisis facilities to avoid unnecessary hospitalization and homelessness. Interdisciplinary, mobile crisis teams provide immediate assistance and may link individuals to community-based respite care (HHS, 1999).

Family Self-Help and Advocacy

As a result of their symptoms and behaviors, people with serious mental illnesses and/or co-occurring substance use disorders often strain the resources of their families to help and may become homeless as a result. Helping families cope with the difficult aspects of living with and providing ongoing assistance to their family members with serious mental illnesses may prevent these individuals from becoming homeless (Lezak and Edgar, 1998).

If family members understand issues such as the cyclic nature of mental illnesses, possible side effects of medication, and what to do when symptoms flare, they often are able to help their relatives maintain residential stability. In some cultures, the family is considered critical to a person's recovery from mental illnesses and substance use disorders, and family members should be involved in treatment, as appropriate.

Respite services give families a much-needed break to the stressful responsibility of providing a home to a family member with a serious mental illness. In addition to their vital role as caretakers, family members can be successful advocates for improved treatment, increased funding, and ongoing research and education designed to improve the lives of all people with serious mental illnesses and/or co-occurring substance use disorders.

Culturally Competent Services

As noted previously, racial, ethnic, and cultural differences can determine how individuals define their problems, how they express them, whether or not they seek help, from whom they will accept help, and the treatment strategies they prefer (HHS, 2001). Practitioners, too, perceive clients through their own cultural lenses.

The basic tenets of cultural competence—*accepting differences, recognizing strengths, and respecting choices*—are critical to providing appropriate services to people who are homeless, especially those who have serious mental illnesses and/or co-occurring substance use disorders. While homeless people do not represent a separate culture per se, they have made adaptations to their circumstances that may affect the choices they make (Milstrey, 1994). For example, behavior that may appear dysfunctional to the clinician may be adaptive for life on the streets.

Agencies that offer culturally adapted services share common strategies. They match clients with providers who have the same language and culture; provide services in minority communities; offer flexible hours and walk-in services; include families in treatment, where appropriate; and allow clergy and traditional healers to participate in the treatment process if the client desires (Flaskerud, 1986; Dana et al., 1992).

Criminal Justice System Initiatives

People with serious mental illnesses and/or co-occurring substance use disorders who are homeless have frequent contact with the legal system, both as offenders and as victims. There are a number of points at which the mental health, substance abuse, and criminal justice systems can work together more effectively to address the multiple needs of people with serious mental illnesses and/or co-occurring substance use disorders in the criminal justice system.

For example, the Sequential Intercept Model, developed by Steadman et al. (The National GAINS Center, unpublished paper) is based on the idea that people move through the criminal justice system in reasonably predictable ways. The five points of interception are: (1) law enforcement/emergency services; (2) initial detention/initial hearings; (3) jails, courts, forensic evaluations, and hospitalization; (4) re-entry; and (5) community corrections and community support. Use of the model helps communities visualize how the local mental health, substance abuse, and criminal justice systems intersect as they serve individuals with mental illnesses and substance use disorders. Interventions at several of these points are described below.

Diversion

Individuals with serious mental illnesses or co-occurring disorders who are homeless can be diverted from the criminal justice system either before or after charges have been filed (pre-booking and post-booking, respectively). Drug, mental health, and homeless courts—sometimes referred to as problem-solving

or collaborative justice courts—are one model of diversion that shows increasing promise for keeping nonviolent offenders with serious mental illnesses and/or co-occurring substance use disorders from cycling in and out of jails and prisons.

Drug courts combine treatment with intensive judicial supervision, mandatory drug testing, and escalating sanctions to help people break the cycle of addiction and the crime that often accompanies it. Individuals also receive such necessary services as education or job skills training.

Research shows that drug courts have an impact on both drug use and recidivism. A National Institute of Justice evaluation of the Nation's first drug court in Miami showed a 33 percent reduction for re-arrests for drug court graduates, compared to other offenders with substance use disorders. Fifty to 65 percent of drug court graduates stopped using drugs (Curie, 2002).

Jurisdictions with drug courts also report savings in jail/prison costs as a result of drug court programs. In 2001, the Drug Court Clearinghouse reported that the average annual number of jail/prison days saved per drug court program was 10,113, for a per program cost savings of $667,694 (DOJ, 2001).

Mental health courts based on this model are being developed to divert people with serious mental illnesses into treatment. An evaluation of the first two years of the Seattle Mental Health Court found that the target population experienced a decrease in criminal justice involvement and an increase in mental health treatment engagement (Haimowitz, 2002).

More recently, communities have begun to adapt this model to help homeless people resolve misdemeanor cases, with the added twist that the court goes to the defendant. "The Homeless Court program brings the law to the streets, the court to the shelters, and the homeless back into society," notes the American Bar Association (Binder, 2002). Participation is voluntary, and "sentences" include life-skills training, 12-step meetings, computer training or literacy classes, job training, counseling, or volunteer work.

The homeless court program began in San Diego in the late 1980s as part of a "stand down" to provide multiple services to homeless veterans. In 1999, the San Diego Public Defender's Office began holding a monthly homeless court at local shelters, which removes barriers to participation for individuals whose days are spent looking for shelter, income, and food. In addition, helping homeless people resolve outstanding warrants and criminal misdemeanor cases paves the way for receipt of such vital services as housing, mental health and/or substance abuse treatment, public benefits, and job training and employment (Binder, 2002).

Comprehensive Services

Diversion programs cannot exist in isolation. They must be part of a comprehensive array of other jail services—including screening, evaluation, short-term treatment, and discharge planning—and must be integrated with community-based mental health and substance abuse treatment, housing, and social services (CMHS, 1995). So-called "boundary spanners" can bridge the

two systems and serve as a liaison among mental health and drug courts, local police, and treatment providers (Steadman, 1992).

Treatment for people in jails and prisons improves justice operations and increases the likelihood that individuals will make a successful return to the community. In her review of effective treatment programs for people with co-occurring mental illnesses and substance use disorders in the justice system, Hills defines a set of program principles for successful outcomes:

- Services for people with co-occurring disorders must focus on the integration of treatment programming;
- Both disorders should be treated as primary;
- Services should be individualized and address symptom severity and skill deficits;
- Psychopharmacological interventions should be used when appropriate;
- Phases of intervention must be tailored to the setting;
- The treatment continuum must extend into the community; and
- Support and self-help groups are critical in successful reintegration to the community (2000).

Re-Entry Planning

Jail stays are frequently short, and some individuals cycle through jails dozen or even hundreds of times without ever being connected to community services. Re-entry planning must begin at admission; otherwise a person with a mental or substance use disorder who enters jail in a state of crisis may leave before the crisis can be addressed. This places individuals at risk of relapse, re-arrest, homelessness, and suicide.

Numerous multisite studies of jail mental health programs suggest best practices for people with co-occurring mental illnesses and substance use disorders who are released from jail. Osher et al. (2002) propose one such model called APIC, which includes the following components:

- *A*ssess the inmate's clinical and social needs and public safety risks;
- *P*lan for the treatment and services required to address the inmate's needs;
- *I*dentify required community and correctional programs responsible for post-release services; and
- *C*oordinate the transition plan to ensure implementation and avoid gaps in care with community-based services.

Jails legally are required to screen and identify inmates with co-occurring disorders and provide crisis intervention and psychiatric stabilization. Successful transition to community services can occur only if the justice, mental health, and substance abuse systems have a capacity and a commitment to work together on behalf of the individuals they serve (Osher et al., 2002).

Supportive housing may be an appropriate adjunct to re-entry planning, according to the Corporation for Supportive Housing, which has prepared a guide to re-entry supportive housing for former inmates (CSH, 2002b). Many of the

individuals who leave jails and prisons are the very same individuals served by supportive housing, including those who face persistent mental health, substance use, and other chronic health challenges, and are at risk of homelessness, the CSH report notes. Again, such an approach requires collaboration and commitment among the housing, health care, social services, and justice systems.

SAMHSA's Leadership in Evidence-Based Practices

SAMHSA has been a leader in the development of evidence-based practices for people with serious mental illnesses and substance use disorders, including those who are homeless. SAMHSA develops technical assistance materials to help providers adapt and adopt evidence-based practices and sponsors grant programs that develop and evaluate science-based interventions for people with mental illnesses and substance use disorders. Some of these programs were described in Chapter 1. Information on additional resources follows. More information on these programs and services is available on the SAMHSA web site at www.samhsa.gov.

The Evidence-Based Practices Project

SAMHSA is a sponsor of the Implementing Evidence-Based Practices for Severe Mental Illness Project, a joint effort of SAMHSA and the Robert Wood Johnson Foundation, the National Alliance for the Mentally Ill (NAMI), and state and local mental health organizations in New Hampshire, Maryland, and Ohio. The project's goal is to develop implementation toolkits to promote the delivery of effective practices for people with serious mental illnesses and/or co-occurring substance use disorders, including those who are homeless.

Each toolkit includes specific information for funders, administrators, clinicians, consumers and recovering persons, and their families. Current toolkit topics include medication management, family psychoeducation, ACT, co-occurring disorders, supported employment, and illness management and recovery.

Community Action Grants for Service System Change

The Community Action Grant for Service System Change program, administered by SAMHSA's CMHS, supports the adoption and implementation of exemplary practices for children with serious emotional disturbances or adults with serious mental illnesses, including those with co-occurring substance use disorders. Phase I grants support consensus-building among key stakeholders to adopt an exemplary practice in their community or state. Phase II grants support implementation of the practice with funds for training and other nondirect services. Both phases of the program include process evaluations.

SAMHSA's CSAT Targeted Capacity Expansion Program

CSAT's Targeted Capacity Expansion (TCE) program helps communities address gaps in treatment capacity. The TCE program supports rapid and strategic responses to demands for substance abuse treatment, including alcohol and drug use services. Grantees may include communities with serious, emerging drug problems, as well as communities with innovative solutions to unmet needs.

Addiction Technology Transfer Centers (ATTCs) and Centers for the Application of Prevention Technology (CAPTs)

SAMHSA uses regionally based centers to help communities adopt evidence-based practices in the prevention and treatment fields. Addiction Technology Transfer Centers (ATTCs) are a nationwide, multidisciplinary resource that transmits the latest knowledge, skills, and attitudes of professional addiction treatment practice. Launched by CSAT in 1993, the ATTC network comprises 14 regional centers and a national office that help treatment systems adopt or adapt evidence-based practices for people with substance use disorders, including those with co-occurring mental illnesses. CAPTs are structured similarly and perform the same function for evidence-based substance use prevention strategies.

Treatment Improvement Protocols (TIPS)

SAMHSA's Treatment Improvement Protocol (TIP) series for substance abuse treatment professionals translates evidence-based research findings in substance abuse treatment to the clinical setting. Each TIP focuses on a specific age group (e.g., adolescents, older adults), a group with special needs (e.g., people with co-occurring disorders, individuals impacted by domestic violence), or a particular clinical practice (e.g., motivational enhancement, brief interventions). TIPs are available at www.SAMHSA.gov/centers/CSAT2002

DEVELOPING SERVICES THAT WILL LAST

Programs that use evidence-based and promising practices can produce positive outcomes for people with serious mental illnesses or co-occurring disorders who are homeless. The ability to show that these services produce measurable results will help sustain programs that are competing for limited funds, often in a managed care environment.

The final two chapters of this report comprise Section IV: Sustain Services. Chapter 7 examines the types of outcomes that can and should be measured and the use of management information systems to track client data. Chapter 8 looks at ways to improve the availability and accessibility of mainstream resources for people with serious mental illnesses and/or co-occurring substance use disorders who are homeless.

Table 6.1

Essential Service System Components

Evidence-Based and Promising Practices

Outreach and Engagement
- Meets immediate and basic needs for food, clothing, and shelter.
- Nonthreatening, flexible approach to engage and connect people to needed services.

Housing with Appropriate Supports
- Includes a range of options from Safe Havens to transitional and permanent supportive housing.
- Combines affordable, independent housing with flexible, supportive services.

Multidisciplinary Treatment Teams/Intensive Case Management
- Provides or arranges for an individual's clinical, housing, and other rehabilitation needs.
- Features low caseloads (10-15:1) and 24-hour service availability.

Integrated Treatment for Co-occurring Disorders
- Features coordinated clinical treatment of both mental illnesses and substance use disorders.
- Reduces alcohol and drug use, homelessness, and the severity of mental health problems.

Motivational Interventions/Stages of Change
- Helps prepare individuals for active treatment; incorporates relapse prevention strategies.
- Must be matched to an individual's stage of recovery.

Modified Therapeutic Communities
- Views the community as the therapeutic method for recovery from substance use.
- Have been successfully adapted for people who are homeless and people with co-occurring disorders.

Self-Help Programs
- Often includes the 12-step method, with a focus on personal responsibility.
- May provide an important source of support for people who are homeless.

Involvement of Consumers and Recovering Persons
- Can serve as positive role models, help reduce stigma, and make good team members.
- Should be actively involved in the planning and delivery of services.

Prevention Services
- Reduces risk factors and enhance protective factors.
- Includes supportive services in housing, discharge planning, and additional support during transition periods.

Other Essential Services

Primary Health Care
- Includes outreach and case management to provide access to a range of comprehensive health services.

Mental Health and Substance Abuse Treatment
- Provides access to a full range of outpatient and inpatient services (e.g., counseling, detox, self-help/peer support).

Psychosocial Rehabilitation
- Helps individuals recover functioning and integrate or re-integrate into their communities.

Income Support and Entitlement Assistance
- Outreach and case management to help people obtain, maintain, and manage their benefits.

Employment, Education, and Training
- Requires assessment, case management, housing, supportive services, job training and placement, and follow-up.

Services for Women
- Programs focus on women's specific needs, e.g., trauma, childcare, parenting, ongoing domestic violence, etc.

Table 6.1
Essential Service System Components (continued)
Other Essential Services (continued)

Low-Demand Services
- Helps engage individuals who initially are unwilling or unable to engage in more formal treatment.

Crisis Care
- Responds quickly with services needed to avoid hospitalization and homelessness.

Family Self-Help/Advocacy
- Helps families cope with family members' illnesses and addictions to prevent homelessness.

Cultural Competence
- Accepts differences, recognizes strengths, and respects choices through culturally adapted services.

Criminal Justice System Initiatives
- Features diversion, treatment, and re-entry strategies to help people remain in or re-enter the community.

SUSTAIN SERVICES

Often, establishing a new program or service for people with serious mental

illnesses and/or co-occurring substance use disorders who are homeless is easier

than sustaining it once initial funds run out. Most government and private funders

want to see a plan for sustainability built into funding applications so they know

that, when their support ends, vital services won't be discontinued. Measuring

outcomes is critical to show potential supporters that your program achieves its

goals and objectives. Planning for sustainability also requires that mainstream

resources be available and accessible to homeless people.

The next two chapters—Measure Results and Use Mainstream Resources to Serve People Who Are Homeless—address these critical areas. These chapters discuss the need to:

- Measure client-level outcomes;
- Measure system-level outcomes;
- Use management information systems;
- Use mainstream resources to prevent homelessness;
- Improve access to mainstream programs;
- Expand the capacity of mainstream programs;
- Promote coordination and collaboration among mainstream programs;
- Build the infrastructure of housing and services; and
- Create public awareness.

Additional information on the materials cited in these chapters can be found in the References. Organizations that offer technical assistance in these areas are listed in the Resources section.
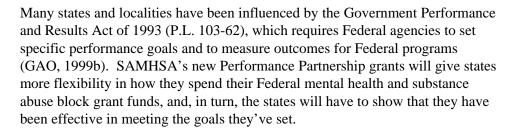
I N   T H I S
S E C T I O N

■   ■   ■   ■   ■   ■   ■

Measure Results

■   ■   ■   ■   ■   ■   ■

**Use Mainstream
Resources to Serve
People Who Are
Homeless**

C H A P T E R

■ ■

7

Measure Results

Significant changes in the financing and delivery of health care, including the rapid development of managed care, have increased the need to monitor and evaluate costs, quality, and access (Kamis-Gould and Hadley, 1996). In the same vein, the Federal, state, and local agencies that fund services for people who are homeless increasingly are using outcome measures to balance service quality and effectiveness with limited resources.

States will have to show that they have been effective in meeting the goals they've set.

Many states and localities have been influenced by the Government Performance and Results Act of 1993 (P.L. 103-62), which requires Federal agencies to set specific performance goals and to measure outcomes for Federal programs (GAO, 1999b). SAMHSA's new Performance Partnership grants will give states more flexibility in how they spend their Federal mental health and substance abuse block grant funds, and, in turn, the states will have to show that they have been effective in meeting the goals they've set.

For programs that serve homeless people, a General Accounting Office report notes, "The use of outcome measures shifts the focus from outputs, such as the types and numbers of activities performed, to the outcomes, or results achieved" (GAO, 1999b). This means, for example, that a provider should include a measure of the number of people who become permanently housed, along with the number of people the program serves.

This chapter examines (1) the rationale for measuring outcomes, (2) the type of outcomes that should be measured, (3) the barriers to measuring outcomes for people with serious mental illnesses and/or co-occurring substance use disorders who are homeless, and (4) the use of management information systems to track client data.

WHY MEASURE OUTCOMES?

Measuring outcomes, first and foremost, is a way to ensure accountability. Positive outcomes provide justification for continued services, which may help programs sustain activities in difficult fiscal environments and/or when start-up funding ends. Agencies also use outcome measures to evaluate their progress in meeting strategic goals and objectives. Beyond these broader aims, some specific reasons to measure outcomes of services for people who are homeless include (HRSA BPHC, 1996):

- *To demonstrate improvements in clients' health status, level of functioning, and quality of life*. Residential stability also is a key indicator that a program has met its goal of helping individuals exit homelessness.
- *To know what works and what doesn't, and to be able to make appropriate interventions more effective*. People with serious mental illnesses and/or co-occurring substance use disorders who are homeless are a heterogeneous group. Measuring the effectiveness of specific interventions helps clinicians know what works for whom, and at what cost.
- *To assist with and assess internal quality improvement efforts*. Agencies can use outcome measures to make internal course corrections that improve the quality of services they offer.
- *To assess cost-effectiveness*. Resources available to serve people who are homeless and people who have serious mental illnesses and/or co-occurring substance use disorders are limited. Providers can demonstrate that timely and appropriate interventions result in cost savings.
- *To assist in resource allocation*. Limited resources necessitate difficult decisions about how to allocate funds among providers and services. Outcome measures can be used to help determine which providers and which interventions are best able to meet clients' needs.
- *To exchange successful strategies*. There is no need for programs that serve people who are homeless to reinvent the wheel. As noted previously in this report, states, communities, and individual agencies can adopt or adapt practices that prove promising, as indicated by the outcomes they achieve.
- *To build support for specific interventions that are effective with people who are homeless*. Showing positive results with vulnerable, high-need individuals can help justify the expenditure of resources for a particular program or approach.
- *To increase client satisfaction*. Though client satisfaction measures may not always relate to successful clinical outcomes, individuals who are satisfied with the type of services offered and the way in which services are delivered may be more likely to complete treatment. For example, offering people a choice in housing relates directly to their success in remaining housed (Srebnik et al., 1995).
- *To demonstrate positive impact on public health and social issues*. Ending homelessness for people with serious mental illnesses and/or co-occurring substance use disorders reduces human suffering; it also reduces the burden on the broader service system. For example, outcome

measures show that people who are housed and receiving appropriate treatment have less contact with the criminal justice system and make less use of emergency room and inpatient care.

Population-specific outcome measures also can help gauge the appropriateness and effectiveness of managed care contracts. In an effort to improve quality and contain costs, many states contract with managed behavioral health care companies to provide mental health and substance abuse treatment to Medicaid recipients. Serious questions have been raised about the ability of managed care companies to respond appropriately to the needs of people with serious mental illnesses or co-occurring disorders who are homeless. State agencies that contract with these organizations can build in specific quality assurance activities and outcome measures relevant to people who are homeless, as well as incentives and sanctions to ensure compliance (Wunsch, 1998).

THE TYPES OF OUTCOMES THAT SHOULD BE MEASURED

Providers who work with people who are homeless and have serious mental illnesses and/or co-occurring substance use disorders agree on the need to measure positive changes in both the client and in the service system. Outcome assessment requires a thorough planning process and the involvement of key stakeholders, including consumers (HRSA BPHC, 1998a).

Programs will measure different client-level and system-level outcomes depending on a number of factors:

■ Population they serve;
■ Specific services they offer;
■ Overall goals and objectives of the organization;
■ Requirements of their primary funding source(s);
■ Role they play in their community's Continuum of Care for people who are homeless; and
■ Political climate in their state or community.

Outcomes measures frequently are expressed in broad terms such as "reduction of barriers" (system-level outcome) or "mental health or substance use status" (client-level outcome). Data collected to support the outcomes typically are articulated as a series of specific measures, often called *performance indicators*. For example, "the number of access points to the system" is a performance indicator for reduction of barriers. Similarly, "the number of psychiatric emergency admissions" is a performance indicator for mental health status.

Some organizations compile outcomes and performance indicators in a document called a *report card*. Report cards have been developed by national oversight organizations, such as the National Committee on Quality Assurance (NCQA) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO); by the insurance industry; and by large corporations. The SAMHSA

Center for Mental Health Services' Mental Health Statistics Improvement Program (MHSIP) has developed the MHSIP Consumer-Oriented Mental Health Report Card (MHSIP, 1996). A report card informs key stakeholders, including policymakers, payers, providers, and consumers, whether the agency or health care system does what is expected and whether it does it well (MHSIP, 1996).

Client-Level Outcomes

Ultimately, the goal of an integrated system of care is to improve client outcomes. For people with serious mental illnesses and/or co-occurring substance use disorders who are homeless, this means improvements in mental symptoms, substance use, housing status, and quality of life. Measures of improved functioning for people with serious mental illnesses or co-occurring disorders who are homeless may include the following outcomes (in bold) and suggested performance indicators (in italics). Although some of these results are difficult to quantify, they are a clear indication that all the preparatory work has been successful (NASMHPD, 1995).

- **Housing status**: Number of days homeless; number of days in housing; length of time in most recent housing placement; possession of housing subsidy;
- **Mental health status**: Number of psychiatric emergency admissions; number of days in inpatient treatment; self-report of mental health status;
- **Substance use status**: Number of days drinking and/or using drugs; number or severity of problems associated with substance use; self-report of substance use;
- **Employment**: Number of days employed; number of work days lost to mental symptoms or substance use;
- **Income**: Average monthly income; receipt of SSI/SSDI or other public benefits;
- **Health status**: Number of acute illnesses; number of inpatient days; self-report of health status; has private or public health insurance;
- **Family relationships**: Self-report of quality of family relationships;
- **Criminal justice involvement**: Number of arrests; number of days incarcerated;
- **Social supports**: Self-report of degree of social support;
- **Consumer satisfaction**: Self-report of satisfaction with a broad range of variables, including housing, mental health, substance use, health status, and degree of social support; and
- **Quality of life**: Measurable improvements in the expected direction in the areas noted above; self-report of perceived quality of life.

System-Level Outcomes

At the system-level, most programs that serve people with serious mental illnesses and/or co-occurring substance use disorders who are homeless will measure access to services, quality of care, and cost-effectiveness. Other system-level outcomes for programs that provide health care services to people who are homeless may include availability of comprehensive services, continuity of care, prevention activities, and degree of client involvement (HRSA BPHC, 1996).

Some specific system-level outcomes for programs that serve people with serious mental illnesses and/or co-occurring substance use disorders who are homeless also might include (NASMHPD, 1995):

- Attention to those not in the system;
- Degree of choice;
- Cultural competence;
- Reduction of barriers;
- Affordable housing options;
- Array of service options;
- Access to services clients want and need;
- Degree to which the mainstream system is responsive; and
- Level of support to maintain progress.

It also is possible to measure the level of systems integration. Measures of improved system performance, designed to gauge the extent to which agencies share information, resources, and clients, include the following performance indicators (HRSA BPHC, 1996; Glover and Gustafson, 1999):

- Number and type of formal interagency agreements;
- Degree of blended funding;
- Number of joint activities between and among providers;
- Extent to which staff from participating agencies are trained in each other's disciplines;
- Degree to which application procedures have been streamlined and exclusionary program rules have been waived;
- Extent to which the system offers "no wrong door" access; and
- Degree to which program planning and development incorporates the participation of key community stakeholders, including consumers.

> *The Massachusetts Division of Medical Assistance has set certain performance standards related to people who are homeless in its contract with the company that provides mental health and substance abuse services for many of the State's Medicaid recipients. For example, one performance standard requires the company to implement measures that will reduce the inappropriate discharge of people from psychiatric facilities to shelters or the streets. Another provides incentives to the company for increasing enrollment of Medicaid-eligible individuals who are homeless (GAO, 1999b).*

BARRIERS TO MEASURING OUTCOMES

There are numerous barriers to measuring outcomes for people with serious mental illnesses and/or co-occurring substance use disorders who are homeless. Indeed, mental illness, substance use, and homelessness each pose special problems in valid and reliable assessment (Mercer-McFadden and Drake, 1992).

These problems are further complicated by the interaction of these conditions, which makes categorizing their progress challenging at best.

If progress is difficult to measure, measuring "success" is even more challenging. Much depends on how success is defined. For people with serious mental illnesses and/or co-occurring substance use disorders, recovery may be incremental and long term, often marked by numerous flare-ups and relapses. Outcome measures therefore, must reflect the intensity of services required to serve people with serious mental illnesses or co-occurring disorders who are homeless, and must recognize the small steps that constitute success (HRSA BPHC, 1996).

Further, the availability of many services that individuals require to exit homelessness, such as supportive housing, may be beyond the ability of individual programs to control. Also, some outcome measures, such as "quality of life," are difficult to quantify, especially when they rely on individual self-reports.

In addition, data collected on program clients cannot capture information on the individuals who are *not* in the system but whose needs may be just as great, if not greater, than those of the individuals being served. Finally, measuring outcomes requires development and implementation of data systems that are sophisticated and user-friendly, as well as staff trained in the use of these tools. Even when the systems and personnel are in place, however, fragmented, duplicative, and inconsistent reporting and evaluation requirements attached to different funding streams pose an ongoing challenge for many providers.

USE OF MANAGEMENT INFORMATION SYSTEMS

Collecting client-level information can help streamline services, reduce duplication of effort, improve access, and inform public policy. Beginning in 2004, the U.S. Department of Housing and Urban Development will require all government and nonprofit agencies receiving McKinney-Vento Homeless Assistance funds to implement homeless information management systems (HMIS) (University of Massachusetts, 2001).

HMIS have already been implemented in 20 to 25 jurisdictions, including several statewide plans and a handful of communities that are pooling resources to build local tracking networks. In other jurisdictions, State and local HMIS efforts are in various stages of planning, pilot testing, and implementation.

The benefits of such systems to individuals who are homeless include streamlined referrals, coordinated case management, and reduction of duplicative intakes and assessments. Service agencies gain reporting tools, mechanisms for internal and external service coordination, and information that can inform service and systems planning and advocacy. Policymakers benefit from data that can include the types and number of services provided, an unduplicated count of

individuals being served, population characteristics and service needs, and trends over time.

States and local jurisdictions implementing HMIS must ensure this data collection is done in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HUD is preparing security and data element guidelines for compliance with HIPAA. Under the guidelines, jurisdictions will be able to decide what information can be shared. To be compliant with HIPAA, any sharing of health information must be done with client consent, and individuals must be informed of what information is being shared and why (NAEH, 2003).

> *In December 2000, the Wisconsin Division of Housing and Intergovernmental Relations purchased a commercial software package to implement a statewide system using a central database, and offered bonus points to agencies applying for funds as an incentive to participate. To date, 84 agencies representing 68 counties participate in the statewide HMIS. The system is designed to protect confidential data and allow clients to determine which records are shared. The HMIS system has reduced or eliminated monthly or quarterly reporting requirements for many agencies, decreased duplicative client intakes, helped coordinate services and streamline referrals, provided better access to data for funders and other stakeholders, and offered on-line access to a statewide database of service providers (University of Massachusetts, 2001).*

CONNECTING TO MAINSTREAM RESOURCES

Weaving best practices for people with serious mental illnesses and/or co-occurring substance use disorders who are homeless into a seamless system of care and measuring the results is a tall order indeed. In the last decade, the homeless service system has created a wealth of programs and services that show positive results for this very vulnerable group. However, the homeless service system does not have the human or financial resources to address this problem fully. The final chapter of this report examines some ways in which mainstream resources can play a vital role in ending homelessness among people with serious mental illnesses or co-occurring disorders.
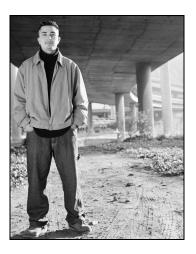
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8

Use Mainstream Resources to Serve People Who Are Homeless

Homeless assistance programs alone cannot prevent or end homelessness (NAEH, 2000). Because most people who are homeless are eligible for, and many already are clients of, mainstream service programs, Federal agencies, states, and communities are actively pursuing ways to make mainstream services more accessible, relevant, and appropriate for people who are homeless. This has taken on new urgency with the Administration's goal to end chronic homelessness.

Mainstream services are vital to provide needed services and supports.

As noted previously in this report, people with serious mental illnesses and/or co-occurring substance use disorders who are homeless are eligible for a host of mainstream health, social service, and income support programs that are intended to meet the needs of all low-income people, though many are not receiving them. These resources are vital to provide needed services and supports that will prevent people from becoming homeless or help them exit homelessness. This chapter examines (1) the type of mainstream benefits for which homeless people with serious mental illnesses and/or co-occurring substance use disorders are eligible and (2) strategies for making mainstream programs available and accessible to homeless people.

A W I D E R A N G E O F A V A I L A B L E R E S O U R C E S

The scope of "mainstream" resources varies depending on the agency or group examining them. In a 1999 report, the GAO identified 50 Federal programs administered by eight Federal agencies that can provide services to homeless people. Of these 50 programs, 16 were targeted for homeless people, and the remaining 34 were nontargeted, or were available to low-income people generally (GAO, 1999a). These nontargeted resources are generally referred to as "mainstream" programs.

In its report on mainstream systems and homelessness, the Charles and Helen Schwab Foundation (2003) defined mainstream resources as:

> …publicly funded programs which provide services, housing and income supports to poor persons whether they are homeless or not. They include programs providing welfare, health care, mental health care, substance abuse treatment and veterans' assistance (p. i).

Using this definition, the Foundation report cites the following mainstream services as being critical for people who are homeless (CHSF, 2003, p. 2):

- Income support programs such as SSI and TANF and supplements such as Food Stamps;
- Medicaid and other health insurance programs, including Community Health Centers and health assistance through the VA;
- Mental health and substance abuse services funded through a variety of Federal block grant programs;
- Workforce Initiative Act (WIA) programs designed to provide training and secure employment for low-income workers receiving benefits; and
- Housing subsidy programs, such as Federal Housing Choice and public housing.

Additional services that affect low-income people include public schools, jails and prisons, child protective services, and foster care.

HHS Mainstream Programs

Of the 34 mainstream programs the GAO identified in 1999, 12 programs are administered by HHS, the parent agency of SAMHSA. The HHS Secretary's Workgroup on Ending Chronic Homelessness identified eight of these programs as relevant to meet the needs of disabled adults who make up the chronically homeless population (HHS, 2003):

- Medicaid;
- TANF;
- Social Services Block Grant;
- Community Services Block Grant;
- Community Health Centers (including Migrant Health Centers);
- Ryan White Programs;
- Substance Abuse Prevention and Treatment Block Grant; and
- Community Mental Health Services Block Grant.

Within these programs, the workgroup found considerable opportunity for the state or grant recipient to tailor service responses to the unique needs of

beneficiaries, including people who are homeless. However, the group also noted (HHS, 2003) that:

- All programs include restrictions on offering certain services. For example, of the eight programs, only Medicaid is authorized to pay for inpatient services.
- The most frequently offered core services (defined as those that are needed to move people from the streets into housing and stabilize their conditions) include information and referral, offered by all eight programs, followed by outreach, supportive case management, and substance abuse services, offered by seven programs.
- Of six supportive services identified as necessary to re-integrate individuals into the community, only one—transportation—is offered by all eight programs. Five of the programs provide all of the supportive services.
- None of the eight programs offer the entire group of core and supportive services the workgroup identified as necessary to prevent and end homelessness among people with serious health and behavioral health disorders.

MAKING MAINSTREAM SERVICES WORK FOR HOMELESS PEOPLE

Researchers, policymakers, and advocates who have examined the issue of using mainstream resources to prevent and end homelessness have developed a set of strategies useful both to homeless service providers and to those who administer and fund mainstream programs. Generally, these strategies fall into six main areas, including:

- Preventing homelessness among clients of mainstream programs;
- Improving access to mainstream resources for people who are homeless;
- Expanding the capacity of mainstream programs to serve people who are homeless;
- Promoting coordination and collaboration among mainstream programs;
- Building the infrastructure of housing and services that homeless people need; and
- Creating public awareness about mental illnesses, substance use disorders, and homelessness.

Each of these strategies is discussed in brief below.

Prevent Homelessness

Homelessness prevention activities within mainstream programs hinge on the fact that most people who become homeless already are clients of publicly funded programs. If these programs don't serve them appropriately, they are at greater risk of homelessness. This is especially true for people with serious mental illnesses and/or co-occurring substance use disorders.

Prevention activities may be as simple as the use of funds to prevent eviction or to help an individual maintain his or her housing. For example, the Massachusetts Public Housing Authority gives preference for Housing Choice vouchers to applicants who are subject to a court-ordered eviction when the applicant's rent exceeds 40 percent of his or her income (CHSF, 2003). In Minnesota, the state pays for up to 90 days of rental housing while an individual with a serious mental illness receives inpatient treatment.

Improving discharge planning is a system-wide effort to prevent homelessness for individuals being released from temporary housing, such as foster care, jails, and psychiatric hospitals. The Massachusetts Housing and Shelter Alliance (MHSA) discovered that many of its clients had been recently released from institutional care. To improve discharge planning, the MHSA advocated for the use of mainstream resources with the mental health, substance abuse treatment, corrections, and foster care systems. The group's success rests in part with its ability to convince the state to evaluate agencies on new performance measures that make homelessness a bad performance outcome (CHSF, 2003). For more information, see http://www.nhchc.org/discharge/discharge_planning_main.htm.

Improve Access to Mainstream Programs

Homeless people face numerous barriers to the receipt of mainstream resources, including barriers that result from the condition of homelessness itself, such as the lack of stable housing from which to receive services (CHSF, 2003). Further, the structure and operations of Federal mainstream programs themselves create additional barriers to serving homeless people (GAO, 2000a).

In its recent report *Ending Chronic Homelessness: Strategies for Action*, HHS proposed several approaches to improve access to mainstream housing and supports for people who are chronically homeless (HHS, 2003). They include:

- *Strengthening outreach and engagement activities*. Mainstream programs that support outreach and case management should be encouraged to identify chronically homeless people as potentially eligible for these services. This can be accomplished by out-stationing or co-locating staff from mainstream programs in homeless service settings. For example, staff of the SSI Outreach Project in Baltimore provide outreach to homeless people who are eligible for SSI and help them through the application process. This began as a demonstration program of SSA and continues today as its own program (CHSF, 2003).
- *Simplifying application procedures*. Complicated, redundant applications for mainstream services pose a significant barrier to people with serious mental illnesses or co-occurring disorders who are homeless. An expert panel convened to advise the GAO on barriers to mainstream resources for homeless people suggested the use of a single application form to gather basic information required for most Federal programs (GAO, 2000a).
- *Improving the eligibility review process*. Lengthy application and appeals processes increase the risk that an individual with a serious

mental illness or co-occurring substance use disorder will become or remain homeless. The HHS report suggests that its Operating Divisions could establish an interagency agreement with SSA to provide cross-training for people who work with homeless individuals on appropriate medical documentation needed to determine disability.

■ *Exploring ways to maintain program eligibility.* Individuals with mental illnesses and/or co-occurring substance use disorders may lose their benefits when institutionalized in a hospital or jail, which makes them vulnerable to homelessness when they leave the facility. HHS encourages states to not terminate Medicaid eligibility for individuals who are institutionalized (HHS, 2003). In Massachusetts, prisoners can be deemed eligible for Medicaid while still in prison and be automatically enrolled on the day of their release (CHSF, 2003).

Expand the Capacity of Mainstream Programs

The homeless service system that has emerged in the 16 years since the original McKinney Act was enacted has compiled an impressive array of evidence-based and promising practices to serve people with serious mental illnesses and/or co-occurring substance use disorders who are homeless. The GAO expert panel noted that Federal agencies could do more to incorporate into mainstream programs the various lessons learned from McKinney-Vento Act programs and demonstration projects targeted to homeless people (GAO, 2000a).

These lessons include the need to (1) integrate services, treatment, income, and housing; (2) link to needed supports; (3) support access to a range of housing options; (4) make services continuously available; and (5) involve consumers in program design and evaluation (HomeBase, 2003). One way to increase the capacity of the mainstream system to provide these services is through the use of training and technical assistance.

For example, HHS recommends training and technical assistance for mainstream service providers on steps that can be taken to end chronic homelessness (HHS, 2003). The State Policy Academies sponsored by HHS and HUD are another example of capacity building. The Policy Academies are designed to help States develop and implement State-specific action plans to identify and address chronic homelessness.

HHS also recommends the use of toolkits and blueprints as technical assistance aids. To this end, HHS and HUD are developing a comprehensive tool to educate and raise awareness among homeless service providers and homeless individuals about various Federal mainstream benefit programs that homeless individuals are eligible for.

Finally, the GAO expert panel called for mainstream providers at the Federal, state, and local levels to be held accountable for serving homeless people, including the development of a set of minimum standards for using program funds (GAO, 2000a). The development and use of homeless-specific outcome measures by mainstream programs will allow the agencies that fund these

services to determine how well they serve people with serious mental illnesses and/or co-occurring substance use disorders who are homeless.

Promote Coordination and Collaboration

The need for greater collaboration among mainstream services on behalf of people who are homeless was one of three top goals cited by HHS in its report on ending chronic homelessness (HHS, 2003). The workgroup that prepared the report recommended, among other strategies that HHS:

- *Provide incentives for states and localities to coordinate services and housing*. One such incentive, for example, might be the ability to use grant funds to support interagency efforts that address chronic homelessness.
- *Reward coordination across HHS assistance programs to address chronic homelessness*. The HHS workgroup proposed, as an example, an incentive program in which States submitting block grant applications that demonstrate a coordinated set of activities across mainstream programs to address chronic homelessness would be eligible for a partial bonus payment up front, with the balance of the bonus based on the achievement of selected performance goals.
- *Permit flexibility in paying for services to individuals experiencing chronic homelessness*. This might be accomplished by allowing states to blend a portion of funds from multiple, relevant HHS assistance programs to target homelessness.

Public systems currently are overburdened and underfunded, making it difficult for them to serve current clients, much less meet increased demands (CHSF, 2003). In the absence of incentives such as those recommended by the HHS workgroup, they rely on the homeless service system to meet the needs of those individuals who have complex problems (NAEH, 2000).

In addition, restrictive eligibility criteria and separate funding streams make it difficult for mainstream programs to cooperate with one another on behalf of people with multiple conditions. However, numerous reports cite examples of innovative financing and program models that serve individuals whose problems cross service system boundaries (e.g., SAMHSA, 2002b; NASMHPD and NASADAD, 2002).

As an outgrowth of its report to Congress on the prevention and treatment of co-occurring mental illnesses and substance use disorders, SAMHSA will disseminate strategies that States and communities have used to address this growing problem. These include strategies to build consensus around the need for an integrated response to the prevention and treatment of co-occurring disorders; to develop aggregated funding mechanisms; to cross-train staff; and to measure success by improvements in client functioning and quality of life.

Build the Infrastructure of Housing and Services

Improving access and coordinating services will be of little use unless there is a full range of housing and services available to which homeless people can be referred. The National Alliance to End Homelessness makes this clear in its report *A Plan: Not a Dream. How to End Homelessness in Ten Years* (NAEH, 2000). "Attempts to change the homeless assistance system must take place within the context of larger efforts to help very poor people," the report notes (p. 2).

In particular, the National Alliance calls for an increase in affordable housing units, an increase in wages that will allow workers to afford housing and needed services, and increases in the availability of such services as mental health and substance abuse treatment and child care. Some additional suggestion follow.

- *Increased entitlements and health insurance benefits.* Many people with serious mental illnesses and/or co-occurring substance use disorders depend on SSI and/or SSDI, and the corresponding health insurance programs, Medicaid and Medicare, respectively. Any increases in these vital benefit programs will help lift these individuals out of poverty and improve their chances of maintaining residential and psychiatric stability.
- *Improved work incentives.* People with serious mental illnesses or co-occurring disorders who are homeless often are afraid to work for fear of losing public benefits, especially health insurance. Though the Ticket to Work and Work Incentives Improvement Act of 1999 addressed some of these issues, questions remain about the usefulness of these incentives for people who are homeless (HRSA BPHC, 2000). Advocates can monitor implementation of this legislation to be certain that people who are homeless are able to take full advantage of its provisions.
- *Increased housing subsidies.* Housing subsidies alone won't solve the problem of homelessness among people with serious mental illnesses and/or co-occurring substance use disorders, especially where affordable housing is in short supply. Yet research reveals that housing subsidies can help people with serious mental illnesses and/or co-occurring substance use disorders who are homeless find independent living arrangements (CMHS, 1994).

Create Public Awareness

Individuals who understand that, with appropriate treatment and support, most people with serious mental illnesses or co-occurring disorders can and do recover may be less likely to discriminate against individuals who have these diseases. Some effective strategies include:

- *Education about the nature of serious mental illnesses and substance use disorders.* Be certain to include the perspective of consumers and recovering persons in all written materials and public forums. Their stories provide powerful testimonies about the strength and resiliency of the human spirit.
- *Education about the causes of homelessness and ways to prevent and end homelessness.* Get the word out to the public and your legislators that *we know what works*. This can be as simple, yet powerful, as inviting a lawmaker to spend a few hours in a shelter or drop-in center. Invite the media to record the event.
- *Community integration of all people with disabilities.* This Nation is poised to improve the lives of all people with disabilities by redoubling its efforts to seek full community integration in housing, employment, and social activities. Take advantage of this momentum to be certain that people with serious mental illnesses and substance use disorders who are homeless benefit fully from these efforts.

M O V I N G   F O R W A R D

Throughout this *Blueprint*, the message is clear: *We know what works to end homelessness among people with serious mental illnesses and/or co-occurring substance use disorders*. The time has come to put what we know to work.

This Nation has learned much and accomplished much since publication in 1992 of *Outcasts on Main Street*. However, *the work is not done*. There is an urgent need, through research and services, to continue to discover the most effective combination of treatment, housing, and supports that will end the cycle of homelessness for people who have serious mental illnesses and/or co-occurring substance use disorders.

The guidance and action steps highlighted in this report are an important first step.

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R ESOURCES

The following organizations offer technical assistance and other information resources in many of the areas covered in this Blueprint. Brief descriptions of the services provided by each are offered below.

F EDERAL R ESOURCES

HRSA's Health Care for the Homeless Information Resource Center
345 Delaware Avenue
Delmar, NY 12054
(888) 439-3300
hch@prainc.com
www.hchirc.bphc.hrsa.gov
Offers front-line providers and program staff access to information regarding clinical practices and funding opportunities, also available are annotated bibliographies and a searchable database of resources on homeless health care issues, and clinical and administrative tools.

SAMHSA's National Clearinghouse for Alcohol and Drug Information
PO Box 2345
Rockville, MD 20847
(800) 729-6686
www.SAMHSA.gov
Collects, prepares, classifies and distributes information concerning alcohol, substance use, prevention strategies and materials, treatment approaches and resources, training programs for professionals and community education programs.

SAMHSA's National Resource Center on Homelessness and Mental Illness
345 Delaware Avenue
Delmar, NY 12054
(800) 444-7415
www.nrchmi.samhsa.gov
The National Resource Center provides technical assistance and comprehensive information concerning the treatment, service and housing needs of people who are homeless and have serious mental illnesses and/or co-occurring substance use disorders.

SAMHSA's National Mental Health Information Center
PO Box 42490
Washington, DC 20015
(800) 789-2647
www.mentalhealth.samhsa.gov
Information Specialists are available to assist with referrals and offer information concerning prevention, treatment and rehabilitation services for mental illnesses.

O T H E R   R E S O U R C E S

Center for Urban Community Services
120 Wall Street, 25th Floor
New York, NY 10005
(212) 801-3300
cucshrc@cucs.org
www.cucs.org
CUCS Housing Resource Center provides technical assistance and training to organizations to help build their capacity to people who are homeless, including supportive housing development and implementation, structuring partnerships, developing service programs and community need assessments.

Corporation for Supportive Housing
50 Broadway, 17th Floor
New York, NY 10004
(212) 986-2966
information@csh.org
www.csh.org
Major repository and distributor of information concerning supportive housing in addition to promoting the expansion of permanent housing linked to services for persons with chronic medical, mental health, and other disabilities who are homeless or at risk of becoming homeless.

National Alliance to End Homelessness
1518 K Street, NW, Suite 206
Washington, DC 20005
(202) 638-1526
naeh@naeh.org
www.naeh.org
Provides assistance to service providers to develop and implement homeless prevention strategies, best practices and profiles, ending homelessness through the housing first approach, service delivery models and employment programs.

National Law Center on Homelessness and Poverty
1411 K Street, NW, Suite 1400
Washington, DC 20005
(202) 628-2535
nlchp@nlchp.org
www.nlchp.org
The Law Center works with groups to prevent and end homelessness by serving as the legal arm of the nationwide movement to end homelessness by addressing contributing factors such as the shortage of affordable housing, insufficient income, and inadequate social services.

Technical Assistance Collaborative
535 Boylston Street, Suite 1301
Boston, MA 02116
(617) 266-5657
info@tacinc.org
www.tacinc.org
Provides information on a full range of federal and mainstream housing programs
and policies that can expand affordable housing for people with disabilities and
who may be homeless. Also provides technical assistance regarding financing of
services and healthcare delivery systems, program design and development,
specializing in behavioral health and housing needs.

U.S. Interagency Council on Homelessness
451 Seventh Street, SW, Suite 2202
Washington, DC 20410
(202) 708-4663
ich@hud.gov
www.ich.gov
Provides Federal leadership for activities assisting families and individuals who
are homeless and technical assistance to community organizations regarding
mainstream resources available to assist people who are homeless.