Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ALCOHOL, DRUG, AND MENTAL HEALTH SERVICES FOR HOMELESS INDIVIDUALS

Richard P. Kusserow
INSPECTOR GENERAL

MARCH 1992

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program, and management problems, and recommends courses to correct them.

OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in these inspection reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

This report was prepared under the direction of William C. Moran, Regional Inspector General, Office of Evaluation and Inspections and Natalie Coen, Deputy Regional Inspector General, Office of Evaluation and Inspections, Region V. Participating in this project were the following people:

<u>Chicago, IL</u>
Barbara Butz (Project Leader)
Jennifer Antico
Pamela S. May
Kate McFadden
Emil J. Posavac

<u>Headquarters</u>
Emilie M. Baebel
Susan E. Hardwick
W. Mark Krushat

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ALCOHOL, DRUG, AND MENTAL HEALTH SERVICES FOR HOMELESS INDIVIDUALS

Richard P. Kusserow
INSPECTOR GENERAL

OEI-05-91-00062

EXECUTIVE SUMMARY

PURPOSE

This inspection examined how States use the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant to serve homeless individuals with mental health, alcohol, or other drug problems.

BACKGROUND

Recent research suggests that approximately one-third of an estimated 600,000 homeless population are severely mentally ill, at least 40 percent have problems with alcohol, and an additional 10 percent abuse other drugs. In addition, it is estimated that at least one-half of the homeless mentally ill population also have alcohol or other drug problems.

The Department's response to homelessness is two-pronged: (1) specially targeted programs for homeless persons and (2) mainstream programs that serve them as part of their service population. The 1987 Stewart B. McKinney Act is the government's major targeted response to the problem of homelessness; the McKinney Projects for Assistance in Transition from Homelessness (PATH) program targets the homeless population with dual diagnosis of serious mental illness and substance abuse disorders. In terms of mainstream programs, the ADMS block grant is one of the Department's largest programs that could serve homeless persons.

The ADMS block grant is administered by the Public Health Service (PHS). States may use ADMS funds for grants to community mental health centers and for substance abuse prevention, treatment, and rehabilitation programs and activities. States are not mandated to serve the homeless population with ADMS monies; however, they may choose them as a special target population.

ADMS funding for fiscal year (FY) 1991 is $1.33 billion; nationally, 20 percent is being spent for mental health services, and 80 percent for substance abuse treatment and prevention. ADMS dollars represent a small portion of total State mental health expenditures; in 1987, they accounted for only 2.3 percent of $9.3 billion spent for mental health nationally. According to the 1990 State Alcohol and Drug Abuse Profile, ADMS dollars represent about 20 percent of all funding for public sector alcohol and drug abuse treatment services.

SCOPE AND METHODOLOGY

Besides the ADMS block grant, this study looked at Medicaid and Supplemental Security Income (SSI). We examined the availability, accessibility and appropriateness

of these mainstream programs for homeless individuals. This report presents findings concerning the ADMS block grant; two other reports present findings related to Medicaid and SSI.

We spoke with 224 ADMS grantees in 10 States: California, Hawaii, Illinois, Ohio, Oregon, Maryland, Missouri, New Jersey, New York, and Texas. A description of the methodology for this inspection is in Appendix A.

FINDINGS

Many providers who receive ADMS dollars say they serve homeless individuals but lack data on numbers served and services provided.

Homeless individuals have problems that are more desperate, severe, and difficult to treat than those of other clients.

For the most part, grantees provide the same services to homeless individuals as to other clients. Some provide special services.

Respondents say their services are appropriate for homeless individuals but incomplete. They frequently refer them elsewhere for services they do not provide, but referrals may not be effective.

Respondents strongly agree that special approaches are needed to serve homeless persons.

RECOMMENDATIONS

We conclude that it is critical for agencies to work together to develop the expertise needed to serve homeless individuals and to ensure comprehensive services for them. Our recommendations emphasize the ideas of linkage and coordination among different levels of government, between government agencies, and within local service systems.

The PHS should provide technical assistance to States and other PHS-funded grantees who serve homeless individuals.

The Alcohol, Drug Abuse, and Mental Health Administration should issue an advisory letter to all States with the next round of funding. The letter should underscore the importance for ADMS grantees to include the following components in serving homeless individuals:

- Specialized training for service providers, shelter personnel, and volunteers, for dealing with the unique problems of this population.

- Developing Memoranda of Understanding or other types of formal agreements with other service providers. Agreements would include information-sharing, cross-training, technical assistance, development of model programs (including

outreach, application procedures, resource referral, and coordination with the broader service community), and model release plans (including housing) for institutionalized persons (i.e. in jails or hospitals).

COMMENTS

We received comments from PHS and the Assistant Secretary for Planning and Evaluation (ASPE). We wish to thank those who commented on this report. The text of their comments is in Appendix C.

Although PHS concurs with the principles underlying our recommendations, they do not agree with us that the ADMS block grant is an appropriate mechanism to implement them. Instead, they propose to rely on their current McKinney-funded programs.

We believe that both the McKinney Act and the ADMS block grant are valuable resources for improving services to this population. A previous OIG study on the McKinney Act revealed widespread agreement among respondents that McKinney alone is not the solution to homelessness, and that greater efforts should be made by mainstream Federal programs to serve the homeless. The ADMS grantees in this study represent an extremely broad and diverse national network of providers, a large majority of whom are providing some level of service to homeless individuals. We do not think that such a broad mainstream program, funded at $1.33 billion, should be overlooked as a mechanism to address the problems identified in this study. We think that PHS, in bringing its resources to bear on this network, can help improve considerably the response of these providers to homeless individuals.

We continue to recommend a strong technical assistance role for PHS. However we have modified our language in the recommendation slightly. We recognize that PHS' primary responsibility is to States for the block grant, and to their local McKinney grantees, who in turn can work - and, we hope, would take every opportunity to do so - with local ADMS grantees.

We revised the first finding and made some editorial changes elsewhere in the report to accommodate concerns raised by PHS and ASPE.

TABLE OF CONTENTS

PAGE

EXECUTIVE SUMMARY

INTRODUCTION 1

Purpose 1

Scope 1

Background 2

Methodology 3

FINDINGS 4

Many providers who receive ADMS dollars say they serve homeless individuals but lack data on numbers served and services provided 4

Homeless individuals have problems that are more desperate, severe, and difficult to treat than those of other clients 5

For the most part, grantees provide the same services to homeless individuals as to other clients. Some provide special services 6

Respondents say their services are appropriate for homeless individuals but incomplete. They frequently refer them elsewhere for services they do not provide, but referrals may not be effective. 7

Respondents strongly agree that special approaches are needed to serve homeless individuals effectively. 8

RECOMMENDATIONS 10

APPENDIX A: Methodology A-1

APPENDIX B: Data Verification Sheet B-1

APPENDIX C: Agency Comments C-1

INTRODUCTION

PURPOSE

This inspection examined how States use the Alcohol, Drug Abuse and Mental Health Services (ADMS) block grant to serve homeless individuals with mental health, alcohol, or other drug problems.

SCOPE

There is no definitive count of the number of homeless people in the United States (U.S.). The Urban Institute estimated in 1988 that between 567,000 and 600,000 are homeless in the U.S. on any given night. In March 1991, the U.S. Census Bureau counted 178,828 persons in emergency shelters and 49,793 persons at pre-identified street locations; however, they acknowledge that this is an undercount.

Recent research suggests that approximately one-third of the homeless population are severely mentally ill, at least 40 percent have problems with alcohol, and an additional 10 percent abuse other drugs. In addition, it is estimated that at least one-half of the homeless mentally ill population also have alcohol or other drug problems; we refer to such persons as the "dually diagnosed" in this report. This study focused on homeless individuals (as opposed to families) with these problems; the terms "the homeless" or "homeless individuals" in the report refer strictly to this population.

Federal efforts to assist homeless persons are two-pronged: (1) specially targeted programs directed at the homeless population, and (2) mainstream programs that serve homeless clients as a portion of their service population. The major Federal targeted response is the 1987 Stewart B. McKinney Act (hereafter referred to as McKinney), funded for fiscal year (FY) 1991 at $682.3 million. The McKinney Projects for Assistance in Transition from Homelessness (PATH) program, funded at $30 million for FY 1992, targets the homeless population with dual diagnosis. A 1990 study by the Office of Inspector General found that while McKinney programs have helped meet emergency needs, respondents did not view McKinney as the long-term solution to homelessness; rather, they advocated greater Federal and State efforts through on-going, mainstream programs.

This inspection looked at three major mainstream programs in the Department which could serve homeless individuals: the ADMS block grant, Medicaid, and Supplemental Security Income (SSI). This report presents findings concerning the ADMS block grant. Two separate reports present findings related to Medicaid and SSI.

We examined the availability, accessibility and appropriateness of each of these mainstream programs for homeless individuals. "Availability" means whether a program

or service exists in an agency or community and homeless individuals are eligible for it. "Accessibility" refers to the ease or difficulty homeless individuals have in finding and utilizing available services. "Appropriateness" refers to whether available, accessible services match the homeless client's needs in a broad sense.

BACKGROUND

The ADMS block grant, funded by the Public Health Service (PHS) through the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) was created under the Omnibus Budget Reconciliation Act of 1981. The block grant is currently administered by the Office for Treatment Improvement (OTI) in ADAMHA. A proposed reorganization plan for ADAMHA could affect the administration of this program.

States may use ADMS block grant funds for grants to community mental health centers, and for substance abuse prevention, treatment, and rehabilitation programs and activities. States are not mandated to serve the homeless population with ADMS monies; however, States may choose homeless persons as a special target population.

ADMS funding for FY 1991 was $1.33 billion. Nationally, 20 percent was being spent for mental health services and 80 percent for substance abuse treatment and prevention. However, this ratio varies significantly across States. In recent years, substance abuse dollars have risen dramatically. In contrast, mental health dollars have remained stable or, in some years, even declined. Recently, there has been growing Congressional interest in how ADMS funds are being used, as well as some interest in separating the mental health from the substance abuse portion of the block grant.

ADMS dollars represent a small portion of total State mental health expenditures. In 1987, ADMS dollars accounted for only 2.3 percent of $9.3 billion spent for mental health nationally. According to the 1990 State Alcohol and Drug Abuse Profile, ADMS dollars represent about 20 percent of all funding for public sector alcohol and drug abuse treatment services.

Several Departmental initiatives impact the homeless population. Two of Secretary Sullivan's 1990 Program Directives relate to this study: 1) Expand the use of cost-effective human services to ensure the quality and availability of effective assistance; and, 2) Improve the health status of minority and low-income persons. Also, the Secretary has created a task force, chaired by the Director of the National Institute of Mental Health, which is charged with identifying barriers to service for severely mentally ill homeless persons.

METHODOLOGY

During pre-inspection we conducted an extensive review of literature, including program descriptions, Federal legislation and regulations, and articles, reports and research papers of all kinds. We also talked with persons at PHS, the Social Security Administration, Health Care Financing Administration; the National Association of State Alcohol and Drug Abuse Directors, the National Association of State Mental Health Program Directors and other related associations; foundations; and experts. We spent two days with a special mobile assessment unit in Chicago.

For the inspection on ADMS, we reviewed portions of the ADMS 1989 State reports and 1990 State plans. We collected additional data from 224 ADMS mental health and substance abuse grantees in 10 States: California, Hawaii, Illinois, Ohio, Oregon, Maryland, Missouri, New Jersey, New York, Texas. We spoke by telephone with the executive directors or program directors of these agencies about the inspection issues related to ADMS. With those who said they serve homeless individuals, we also discussed issues related to Medicaid and SSI.

Our review was conducted in accordance with the *Interim Standards for Inspections* issued by the President's Council on Integrity and Efficiency. A detailed description of the methodology for this inspection is in Appendix A.

FINDINGS

Finding #1: Many providers who receive ADMS dollars say they serve homeless individuals but lack data on numbers served and services provided.

We contacted 224 mental health and substance providers who States identified as recipients of ADMS funds. Our first goal was to learn whether these providers serve homeless individuals at all, regardless of how many they serve or the extent of services. On the basis of this very broad criterion, 168 of the 224 told us that they provide services of some sort to homeless individuals.

For many of these 168 grantees, ADMS dollars are a small portion of the budget. When we compared the ADMS grants of these 168 agencies (reported by States) with their annual budgets (reported by the agencies), we found that for roughly 60 percent, ADMS dollars were only 10 percent or less of the annual budget.

While we recognize that ADMS funds may be a small part of their budgets in some cases, we nevertheless believe that these agencies represent a broad and diverse network of mainstream providers whose services can be important in a solution to homelessness. They include community mental health centers, community health centers, cities and counties, regional boards, public and private not-for-profit agencies of all types, hospitals, school boards, and others.

Whether ADMS dollars were a small proportion of their budget or not, we were interested in (1) whether these providers use ADMS funds, specifically, to serve homeless individuals, and (2) what ADMS-funded services they provide to them. Unfortunately, few respondents were able to answer these questions. Some did not realize that their agency received ADMS funds; others knew but said that their agency does not track these dollars separately. And, we learned that few of these agencies are tracking homeless clients or the services they receive, whether ADMS-funded or not.

We then asked these respondents how many homeless individuals their agency served in the previous program year. Again, many did not know because they lack data. Fifteen percent did not answer the question at all and half only gave a ball-park estimate. For the few who did give a hard number, we were not always confident of its reliability. Sometimes we suspected that it represented a duplicated count or included all homeless clients served, including families, rather than solely individuals with mental health, alcohol or other drug problems.

The services these respondents most often said their agencies provide - to all clients in general, and whatever the funding source - are: outpatient mental health and outpatient substance abuse services. Half provide both of these services, with mental health grantees far more likely to provide both than substance abuse grantees. Smaller

proportions provide inpatient mental health or substance abuse services, or detox services. A few grantees offer none of these services but rather case management, information and referral, education, or prevention services instead.

The rest of this report presents what these 168 respondents said about the homeless individuals they serve and the services they provide to them. We refer to these respondents subsequently in this report as "ADMS grantees."

Finding #2: Homeless individuals have problems that are more desperate, severe, and difficult to treat than those of other clients.

As a backdrop to any discussion of the availability, accessibility and appropriateness of the services of ADMS grantees for homeless individuals with alcohol, drug or mental health problems, it is important to note that this is a very needy population. Over four-fifths of our respondents said that the needs of the homeless clients they serve differ significantly from the needs of their other clients.

Of the 293 comments they made about the differences between homeless individuals and other clients, 290 referred to the severity of the problems of the homeless. Only three respondents said that homeless people respond more positively to assistance compared to other clients; however, the reason given was that homeless clients "are more desperate."

The overwhelming impression made by these respondents is that homeless persons are indeed more desperate. In Figure 1 is a list of some of the many ways in which they said the needs of homeless clients differ from those of their other clients.

The most frequent comments emphasized that homeless individuals need more comprehensive services, stable homes, more social supports, and basic medical care. Person after person stressed that their homeless clients were the neediest among the needy, that being homeless exacerbates all other physical or emotional problems while at the same time creating new problems. One respondent summarized the sense of many other comments: "They're at the absolute bottom when they get to us."

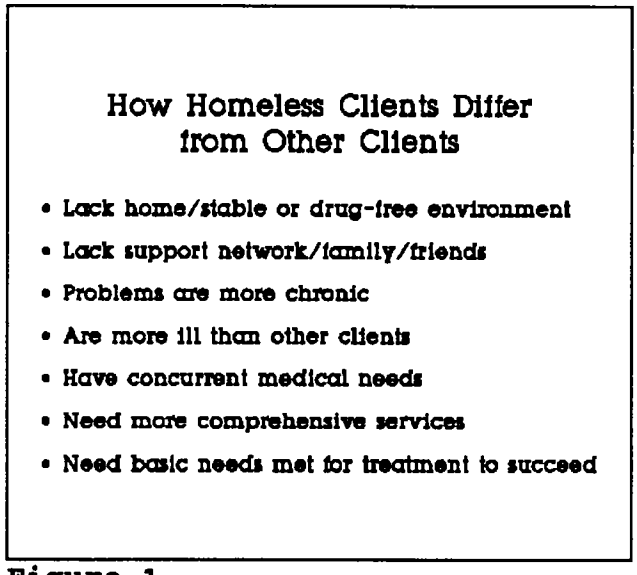

Figure 1

Respondents also pointed out that homelessness increases the difficulty of treating mental illness and substance abuse. Many said that homeless people often require long-term treatment yet live day-

to-day; display a very short time perspective, thinking of only the immediate future; need mental health treatment, but distrust, resist, and fear those who try to help; or are transient - "a moving target," as one respondent called them.

Respondents reported that it can be too difficult to provide long-term treatment, even when a homeless person requests help. Some said that it is necessary to stabilize these clients with temporary housing, food or medical care for treatment to be effective. Others said that when homeless people seek service, it may well be during an acute crisis; they may demand immediate attention when they approach an agency, wanting only a "quick fix." They may approach an agency numerous times for such help, cycling in and out for short periods rather than remaining for long-term treatment.

Given their many needs, homeless clients must seek out help from a vast array of service providers: welfare agencies, Social Security district offices, community mental health centers, community health centers, clinics, emergency rooms, alcohol or drug programs, shelters and food pantries, and others. The severity of their problems may make it difficult for them to find appropriate help on their own.

Finding #3: For the most part, grantees provide the same services to homeless individuals as to other clients. Some provide special services.

Less than one-quarter of the ADMS grantees who serve homeless individuals do any outreach targeted specifically at them. Rather, homeless individuals come to them in a variety of ways. The most frequently mentioned is "walk-ins;" nearly 70 percent mentioned this. However, they are also referred by social service agencies, shelters or missions, police, and the courts. Substance abuse grantees were more likely than mental health grantees to report walk-ins (73 vs 60 percent) and court referrals (48 vs 19 percent); mental health grantees were more likely to mention hospital referrals (32 vs 18 percent) and general, non-targeted outreach (30 vs 16 percent).

Once they make their way into these agencies, homeless individuals are most likely to receive the same services as non-homeless clients. The most frequently mentioned services which they share with other clients are residential treatment, outpatient mental health counseling, outpatient substance abuse counseling, and case management. In addition, 20-25 percent of our respondents mentioned that their agency provides other services such as psychotropic medication, information and referral, medical care, vocational rehabilitation, or job placement.

Forty-five ADMS grantees (29 percent) also make special services of some sort available to homeless individuals: 35 percent of the mental health grantees and 25 percent of the substance abuse grantees. These services differ primarily by being more intensive and beginning to address fundamental needs for housing, food, and medical care. Many of these respondents also said they use special service-delivery approaches such as outreach, drop-in centers, or case management to serve homeless individuals.

Seventeen of these 45 grantees receive McKinney funding of some sort for these special services. Three-quarters of them said they had developed these services in response to a Federal or State initiative; 40 percent specifically mentioned McKinney. This was the only evidence we found that of a specific Federal initiative that had influenced ADMS grantees to develop services specifically for homeless individuals. The majority of ADMS respondents we spoke with - most of them agency directors or program directors - knew little about McKinney programs or Federal policies on homelessness in general.

Finding #4: Respondents say their services are appropriate for homeless individuals but incomplete. They frequently refer them elsewhere for services they do not provide, but referrals may not be effective.

Respondents believe that their agencies' services are generally appropriate for homeless individuals.

Despite differing perceptions of the homeless population and their needs, most respondents described their agencies' services, in a general sense, as appropriate for them. However they express a sense of frustration at not being able to provide a sufficiently broad range of services for homeless people, sufficiently flexible services to engage them in treatment, and sufficiently intensive services to meet their needs for for stability, structure, and social support.

Comments about the appropriateness of services reflect the fact that this is not a homogeneous population. Respondents did not agree about the best way to approach treatment for homeless individuals, nor did they recommend any single approach as the most appropriate. Indeed, their comments reveal that they feel pulled in conflicting directions in working with them.

Almost all respondents refer homeless individuals to other agencies for services they themselves do not offer. However, clients may not follow through, or may not be able to access services elsewhere.

Ninety-six percent of respondents report making referrals; over 80 percent report making "frequent" referrals. The most common referrals are for: emergency, permanent, or transitional housing; primary medical or dental care; and vocational rehabilitation or training. More referrals are made to social service agencies and emergency shelters than to other types of service providers. A number of respondents commented that some of their homeless clients need vocational training but there is no vocational program to refer them to.

Referral may not be effective. A number of respondents said homeless people will often not continue to search for an agency even upon referral. Follow-through may take more persistence or resources than the life circumstances of homeless persons allow. Lacking a watch or money for transportation, for example, can make it difficult

to follow through. Or, sometimes homeless persons may not follow through because, as one respondent noted, they "have lost hope."

Referral may also not succeed because access to the services where homeless clients are referred is limited. We asked respondents whether homeless individuals have problems accessing services from other mental health or substance abuse providers in their communities. Over 80 percent of them said there were problems; two-thirds mentioned multiple problems.

As illustrated in Figure 2, some of these problems relate to the instability of homeless individuals and their transient lifestyle, and others to the service system itself. The most frequently mentioned is that other service providers see homeless individuals as undesirable clients, either because they look or act strange, are dirty or unkempt, resist treatment, don't follow through with appointments, don't conform to agency procedures or rules, or "agencies know that treatment of the homeless is a lot of work, so they don't encourage them." Other frequently mentioned barriers were: waiting lists or lack of openings in a program, lack of transportation, and a lack of health insurance or funds to pay for services.

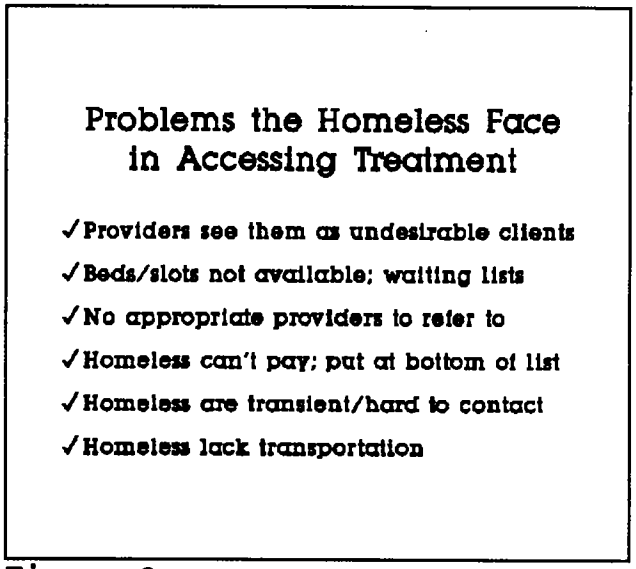

Figure 2

Nearly one-fifth of our respondents said there are no appropriate service providers available to which to refer homeless individuals; a few specifically mentioned a lack of programs for the dually diagnosed. And, some respondents commented generally that there is community resistance towards developing programs because residents fear homeless people.

Finding #5: Respondents strongly agree that special approaches are needed to serve homeless individuals effectively.

Respondents were in marked agreement that, in terms of reaching a long-term solution to homelessness for this population, services must be modified in some way to serve them effectively.

Some of the more general suggestions made were: (1) homeless individuals need to be approached in ways that engage them in treatment; (2) comprehensive services are needed to stabilize these clients, since treatment cannot be expected to be helpful with people who return to parks or metal grates to sleep at night; and, (3) service providers should offer less compartmentalized, more flexible services. The picture that emerges

of an "ideal" service provider is one that reaches out to homeless clients and, at a single location, meets all their needs - not only those most immediately evident (such as food, shelter, and medical care) but those related to alcohol or drug dependence, mental illness, lack of housing, and joblessness.

Respondents made many other more specific suggestions on how services to this population could be enhanced: special outreach; a housing component of some kind; medical services; specially-trained staff; better coordinated programs to overcome the fragmentation of the social welfare system; and, special programs for the dually diagnosed.

On a related issue, we asked respondents whether they thought that homeless individuals need separate mental health or substance abuse programs designed specifically for them, that is, programs set apart from the traditional treatment system. We found that opinion was split on this issue: 54 percent favored separate programs and 42 percent felt that they were neither needed or desirable. Significantly, however, almost three-quarters of those opposed to separate programs, still felt that traditional services should incorporate different approaches of some kind - special outreach, for example - to reach this population.

RECOMMENDATIONS

This study confirmed earlier findings that homeless individuals have severe, multi-faceted problems. Their many needs range from the basics of food and shelter to more complex needs for mental health and substance abuse treatment. Agencies try to meet these many needs, but experience great difficulty in doing so - often due to lack of resources.

As stated in our findings, 96 percent of ADMS respondents told us that they must refer clients to other providers for services they are unable to provide. Yet the referral process is often an obstacle for homeless people seeking help. Some lack the skills to follow through; others may not have transportation to the assortment of agencies they must visit for services. The result is that many homeless individuals fall through the cracks and go unserved. This, combined with various obstacles inherent in the service system itself that limit the availability or accessibility of services, may limit access to services for them.

We conclude that it is critical for agencies to work together to develop the expertise needed to serve homeless individuals and to ensure comprehensive services for this population. Our recommendations emphasize the ideas of linkage and coordination among different levels of government, between government agencies, and within local service systems. The themes of linkage and coordination are stressed in all three reports related to this inspection (see separate reports on SSI and Medicaid). We should also note that the Secretary named service integration a priority for the homeless population in a speech in the spring of 1991.

In many States, linkage and coordination are already priorities, while in others they have yet to be developed. At the end of our study, we spoke with the coordinators for the McKinney-funded Projects for Assistance in Transition from Homelessness (PATH) programs in the 10 sample States to generally discuss potential recommendations arising from this study. They agreed that linkage and coordination are critical elements for serving such a needy population.

Constructing recommendations that will have widespread impact is difficult, since there is such a large variety of service providers and funding streams. Furthermore, the scope of our recommendations is limited by the nature of ADMS as a block grant program. Also, we are mindful that ADMS grantees are only one group of providers among many who serve homeless individuals, and that ADMS dollars are only one piece of the funding pie.

Nevertheless, we do consider ADMS a valuable resource for homeless individuals. ADMS grantees represent a large network of service providers nationally who can supply both treatment and other needed services. It appears that the majority are

already serving homeless individuals, albeit in a limited way for the most part. We believe, therefore, that the ADMS block grant should not be overlooked as a resource for homeless individuals.

Our goal in these recommendations is to facilitate a first step toward a long-term solution for homeless individuals who are mentally ill or have alcohol or other drug problems. They are designed to help reduce the number of homeless individuals who go unserved and to ensure comprehensive services that are accessible and appropriate for this population.

Recommendation #1: The PHS should provide technical assistance to States and other PHS-funded grantees who serve homeless individuals.

The technical assistance provided should include, but not be limited to, the two items specified in Recommendation #2 below.

Recommendation #2: The ADAMHA should issue an advisory letter to all States with the next round of funding. The letter should underscore the importance for ADMS grantees to include the following components in serving homeless individuals with mental health, alcohol, or drug problems:

- Specialized training for service providers, shelter personnel, and volunteers for dealing with the unique problems of this population. For example, agency personnel should be trained to work with staff from State mental institutions, jails, nursing homes, and other residential settings to develop release plans for individuals coming out of these institutions.

- Memoranda of Understanding or other formal agreements with other agencies in the community. These would address information sharing, cross-training, technical assistance, development of model programs (including outreach, application procedures, resource referral, and coordination with the broader service community), and model release plans (including housing) for institutionalized persons.

  Other agencies would include, but not be limited to, Social Security district offices, McKinney-funded providers, local mental health and substance abuse authorities and departments, and local welfare offices.

COMMENTS

We received comments from PHS and the Assistant Secretary for Planning and Evaluation (ASPE). We wish to thank those who commented on this report. The text of their comments is in Appendix C.

Although PHS concurs with the principles underlying our recommendations, they do not

agree with us that the ADMS block grant is an appropriate mechanism to implement them. Instead, they propose to rely on their current McKinney-funded programs.

We believe that both the McKinney Act and the ADMS block grant are valuable resources for improving services to this population. A previous OIG study on the McKinney Act revealed widespread agreement among respondents that McKinney alone is not the solution to homelessness, and that greater efforts should be made by mainstream Federal programs to serve the homeless. The ADMS grantees in this study represent an extremely broad and diverse national network of providers, a large majority of whom are providing some level of service to homeless individuals. We do not think that such a broad mainstream program, funded at $1.33 billion, should be overlooked as a mechanism to address the problems identified in this study. We think that PHS, in bringing its resources to bear on this network, can help improve considerably the response of these providers to homeless individuals.

We continue to recommend a strong technical assistance role for PHS. However we have modified our language in the recommendation slightly. We recognize that PHS' primary responsibility is to States for the block grant, and to their local McKinney grantees, who in turn can work - and, we hope, would take every opportunity to do so - with local ADMS grantees.

We revised the first finding and made some editorial changes elsewhere in the report to accommodate concerns raised by PHS and ASPE.

APPENDIX A

GENERAL COMMENTS REGARDING THE DATA

We collected both qualitative and quantitative data for this inspection. The qualitative data presented in the reports is not weighted. Quantitative ADMS data was used to make national projections (described later in this Appendix) based on weighted State averages for our sample States. For the most part, data collected from ADAMHA, States and respondents was for 12 month periods representing fiscal years 1989 or 1990.

In general, data from States and respondents regarding ADMS expenditures was very difficult to obtain as well as extremely variable. They rarely kept this data in a complete or uniform manner. Also, State fiscal years varied, as did those of respondents.

STATE SAMPLE SELECTION

We used a stratified, multi-stage methodology in choosing States, since we intended to make national projections with the quantitative data. We wanted to talk to ADMS grantees and certain McKinney-funded grantees (described later in the Appendix), who could discuss Medicaid and SSI. Thus we divided the 50 States into two categories: those with both ADMS grantees and more than one McKinney grantee, and those with ADMS grantees and one or no McKinney grantees. (As noted in the Methodology section, McKinney respondents were Health Care for the Homeless grantees or grantees of research and demonstration projects funded by ADAMHA.) We selected six States from the first category and four States from the latter. The sample States from each category were selected, with replacement, based on probability proportional to the estimated FY 1991 ADMS funding.

The table lists the sample States, estimated amount of ADMS 1991 funding, and the States' percent of total ADMS funding. The sample represents a significant portion of total ADMS funds.

STATE	ESTIMATED ADMS FUNDS FOR FY 1991	PERCENT OF TOTAL ADMS FUNDS
California	$151,048,450	13%
Hawaii	6,077,746	1%
Illinois	62,484,994	5%
Maryland	23,274,979	2%
Missouri	22,789,494	2%

New Jersey	47,169,435	4%
New York	103,642,170	9%
Ohio	56,646,814	5%
Oregon	12,583,566	1%
Texas	73,452,804	6%
Total	$559,530,452	47%

Total FY 1991 Estimated ADMS Funding	$1,187,357,962

SAMPLING METHODOLOGY FOR ADMS RESPONDENTS

We intended to sample 30 grantees from each State which would represent a proportional mix of mental health and substance abuse grantees. Respondents were program directors or managers. The number of grantees sampled in each of these two categories was determined by the proportion of FY 89 mental health ADMS funding to substance abuse funding in each State. This was the most recent year for which States had this information. We contacted the 10 States and asked for the amount of ADMS funds they received in FY 1989, and the total amount that went to mental health grantees and substance abuse grantees. In addition, we asked for a listing of the mental health grantees and substance abuse grantees and the amount of ADMS funding each received.

In most States, mental health and substance abuse grantees were then selected with probability proportional to the amount of the ADMS grant received. In instances where the grant money was given to counties, we selected six counties proportional to mental health and substance abuse funding. We then selected five grantees within each county with probability proportional to the amount of the ADMS grant received.

There were some exceptions to these two basic methodologies. In those States where the amount of ADMS grant money for 1989 was not readily available, we chose a simple random sample of grantees. In instances where a grantee subcontracted over 50 percent of its ADMS funds, we asked the grantee to identify the two subgrantees who received the largest proportion of grant funds, whom we then interviewed.

Several grantees were dropped because they were no longer receiving ADMS funds in FY 1991. Our final sample consisted of 224 grantees in 10 States. There were 95 mental health and 129 substance abuse grantees. The subsampling in each State was independent of that conducted in any other State.

This methodology enabled us to capture, in most cases, a significant portion of States' ADMS funds in our sample. The following table gives the percent of ADMS mental health and substance abuse FY 1989 funds sampled in each State.

STATE	PERCENT OF SAMPLED ADMS MENTAL HEALTH FUNDS TO TOTAL STATE ADMS MENTAL HEALTH FUNDS	PERCENT OF SAMPLED ADMS SUBSTANCE ABUSE FUNDS TO TOTAL STATE ADMS SUBSTANCE ABUSE FUNDS
California	24%	12%
Hawaii	82%	54%
Illinois	62%	46%
Maryland	41%	35%
Missouri	77%	39%
New Jersey	45%	22%
New York	12%	28%
Ohio	12%	44%
Oregon	68%	39%
Texas	78%	14%

We spoke with sampled respondents by telephone. Our first objective was to learn if the grantees served homeless individuals. We did not pursue further questions with the 56 grantees who said they do not serve the homeless. We discussed the availability, accessibility and appropriateness of their services and Medicaid and SSI for this homeless population, with 168 grantees who did serve them. We also asked respondents to provide basic data on their total agency budget and ADMS grant, clients served, including homeless clients, and Medicaid reimbursement.

ADMS PROJECTIONS

We made two national projections in this inspection: (1) the percent of ADMS going to grantees that told us that homeless individuals were among their served population, and (2) Medicaid funds as a percent of total budget of the grantees. The projections are based on what these ADMS respondents told us. In some cases, they could not give us numbers, or could only give estimates. The Data Verification Sheet we sent to respondents prior to calling them is in Appendix B.

The definition of "homeless" we asked respondents to use in providing this information was: "A person who is not a member of a homeless family, and who lacks stable housing (including a person whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, or a person who is a resident in transitional housing."

These projections are based upon unbiased estimates derived from the sample of grantees within each State. Estimates of the totals, and the variance associated with each total, accounting for the sub-sampling within each State, were calculated using methods described by Cochran[1]. Given these totals, the percentages, as ratios, were easily derived.

The results of these estimates are presented, by State and overall, in the following tables.

[1] Cochran, William G., (1977) Sampling Techniques. John Wiley & Sons, New York, Sec. 11.9, pg. 306.

Percent of ADMS Money Associated with
Grantees Serving Homeless

	Mental Health Grantees	Substance Abuse Grantees
NEW JERSEY	100.0%	64.7%
MISSOURI	92.9%	91.7%
CALIFORNIA	45.1%	77.9%
OHIO	75.7%	83.8%
ILLINOIS	66.7%	93.3%
NEW YORK	8.8%	64.0%
Strata Avg	71.5%	72.4%
TEXAS	82.4%	75.0%
MARYLAND	87.5%	100.0%
OREGON	98.9%	84.0%
HAWAII	38.5%	60.0%
Strata Avg	72.4%	74.9%
Overall Avg	71.8%	75.8%
Std. Err.	21.8%	21.8%
Precision[2]	49.5%	47.8%
L 90% CI	35.9%	39.9%
U 90% CI	107.6%	111.6%

Because of the extreme variability in the data, the upper 90 percent confidence limit exceeds 100 percent. Logically, the upper limit should be truncated at 100 percent. The coefficient of variation for Mental Health programs is 30 percent and that for Substance Abuse programs is 29 percent.

[2] The precision is defined as the semi-width of the confidence interval as a percent of the estimated mean.

Medicaid Funds as a Percent of Total Budget
by Type of ADMS Grantee

	MH	SA
NEW JERSEY	18.9%	0.3%
MISSOURI	8.1%	13.2%
CALIFORNIA	16.5%	6.8%
OHIO	25.8%	12.8%
ILLINOIS	7.1%	5.7%
NEW YORK	3.0%	35.3%
	13.0%	13.7%
TEXAS	1.6%	1.8%
MARYLAND	15.2%	0.3%
OREGON	28.3%	4.1%
HAWAII	0.0%	0.3%
	7.2%	1.7%
Weighted Avg	9.1%	5.6%
Std Err	1.82%	0.87%
Precision[3]	33.0%	25.5%
C.V.	20.0%	15.5%
L 90% CI	6.1%	4.2%
U 90% CI	12.1%	7.0%

This data demonstrates less variability than that in the ADMS funds data. However, the coefficient of variation is below 10 percent for only one of the estimates, the percent homeless among Mental Health grantees.

[3] The precision is defined as the semi-width of the confidence interval as a percent of the estimated mean.

SAMPLING METHODOLOGY FOR OTHER RESPONDENTS

McKinney Grantees

The 33 McKinney grantees in our sampled States included 25 Health Care for the Homeless grantees and 8 other providers who have received McKinney research demonstration grants from either the National Institute for Mental Health or the National Institute on Alcohol Abuse and Alcoholism. We spoke by telephone or in person with these respondents. The focus of our discussions was the availability, accessibility and appropriateness of Medicaid and SSI. We were especially interested in comparing their perspectives - as providers whose mandate is to serve the homeless - with those of ADMS grantees, who have a much broader mandate.

Social Security District Office Respondents

These 25 respondents included district managers, assistant district managers and claims and service representatives in district offices near the McKinney grantees in the sample. We discussed their experiences serving this population, their opinions about how to enhance access to SSI for them, and their views on the role of SSI in a long-term solution to homelessness.

State Medicaid Staff

For background, we reviewed portions of the Medicaid plan for each of the 10 sample States, looking at eligibility criteria and services relevant to homeless mentally ill or substance abusing individuals. We then talked by telephone with 16 Medicaid staff in the 10 States to clarify our understanding of eligibility and services, and to ask if there were any special State Medicaid policies, procedures or special initiatives which affect this population.

APPENDIX B

DATA VERIFICATION SHEET

Please have the following background information available for our telephone discussion; do not return it to us by mail. If possible, we want this data for Federal Fiscal year (FFY) 1990. However, if you maintain data on a State fiscal year (SFY) or calendar year instead, please tell us when we call.

Please provide only the information that you maintain in your existing management information system; otherwise, do not generate it specifically for us. We realize that you may not know or keep some of this information. In this case, we ask that you provide your best estimate, if you are comfortable with doing so. If not, just tell us you don't know.

For FFY, SFY or Calendar 1990	ACTUAL or	ESTIMATED
1. Total agency budget:	$_____	_____
2. Total ADMS[1] block grant funds received:	$_____	_____
3. Total McKinney funds received:	$ _____	_____
4. Total clients served by your agency (unduplicated count; all programs or services):	_____	_____
5. Total clients served by your agency (unduplicated count) with ADMS dollars:	_____	_____

[1]Alcohol, Drug Abuse and Mental Health Services Block Grant

DATA VERIFICATION SHEET
PAGE TWO

6. Total homeless individuals[2] over 18 served by your agency (unduplicated count) ..... _____ _____

a. # mentally ill (no substance abuse problem): _____ _____

b. # substance abusers (not mentally ill): _____ _____

c. # dually diagnosed (both problems) _____ _____

7. Total homeless individuals over 18 served by your agency with ADMS dollars (unduplicated count) ..... _____ _____

a. # mentally ill (no substance abuse problem): _____ _____

b. # substance abusers (not mentally ill): _____ _____

c. # dually diagnosed (mentally ill and substance abusing) _____ _____

8. Total Medicaid reimbursement OR percent of total agency budget that was Medicaid reimbursement _____ _____

9. Number OR percent of total clients served by your agency who were on Medicaid _____ _____

10. Number OR percent of total homeless individuals over 18 served by your agency who were:

on Medicaid: _____ _____

on SSI: _____ _____

---

[2]Person who is not a member of a homeless family, and who lacks stable housing (including a person whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, or a person who is a resident in transitional housing.)

APPENDIX C

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date FEB -7 1992

From Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Report "Alcohol, Drug, and Mental Health Services for Homeless Individuals"

To Inspector General, OS

Attached are the Public Health Service's (PHS) comments on the subject OIG draft report. The report recommends that PHS: (1) provide technical assistance to State and local Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant recipients and other PHS-funded grantees who serve homeless individuals, and (2) issue an advisory letter to all States underscoring the importance for ADMS grantees to include specialized training and formal agreements with other community social services agencies in serving homeless individuals with alcohol, drug abuse, or mental health (ADM) problems.

We concur with the principles underlying these recommendations, and explain that the ADMS Block Grant may not be the most appropriate mechanism to implement the recommendations. Congress chose to target the problems of the homeless population through the McKinney Act. The McKinney Projects for Assistance in Transition from Homelessness is the program that targets the homeless population with dual diagnoses of serious mental illness and substance abuse disorders.

In our comments, we note that PHS has provided and will continue to provide a variety of technical assistance to the States and its other grant recipients. We highlight activities undertaken by the Alcohol, Drug Abuse, and Mental Health Administration to address the programmatic needs of homeless individuals with ADM disorders. We identify activities administered by the National Institute on Alcohol Abuse and Alcoholism that evaluate the effectiveness of comprehensive service interventions designed to meet the special needs of various subgroups of homeless individuals. Lastly, we mention research and demonstration programs administered by the National Institute of Mental Health for homeless mentally ill individuals.

Though we do not specifically comment on the recommendations in the companion OIG draft reports on Medicaid and Supplemental Security Income (SSI) for homeless individuals, we see these programs as essential components of an overall strategy for meeting the needs of homeless individuals with ADM disorders. We are prepared to take appropriate actions to bring about

greater cooperation and collaboration between PHS programs and Medicaid and SSI.

We include also a series of technical comments for your consideration.

James O. Mason

James O. Mason, M.D., Dr.P.H.

Attachment

PUBLIC HEALTH SERVICE (PHS) COMMENTS ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORTS "ALCOHOL, DRUG, AND MENTAL HEALTH SERVICES FOR HOMELESS INDIVIDUALS;" "MEDICAID AND HOMELESS INDIVIDUALS;" AND "SUPPLEMENTAL SECURITY INCOME AND HOMELESS INDIVIDUALS"

General Comments

These three reports present the findings and recommendations of a study looking at three large, main-stream programs that could serve homeless individuals as part of their service population: the Alcohol, Drug Abuse, and Mental Health Services (ADMS) Block Grant; Medicaid; and Supplemental Security Income. All three reports rely on the same methodology: interviews with Federal program staff and national organization representatives; and telephone surveys of a sample of local ADMS grantees in ten randomly selected States, McKinney Mental Health Care for the Homeless Block Grant and research demonstration grantees in those States, as well as staff in the State Medicaid and Social Security district office in the same areas as the McKinney respondents.

The general findings across the three studies agree with information from other sources. For example, these studies document the extensive service needs of homeless individuals and the difficulties they face in accessing and maintaining eligibility for these services. Enhanced coordination of the many programs that provided services to the homeless population is generally a common theme in many studies. The divergence of opinion between service providers and mainstream program officials over the role of those programs in providing assistance to homeless individuals has also been frequently discussed. However, much of this information is anecdotal; very little systematic data is available with the exception of a few studies in individual localities or treatment settings.

We also want to emphasize two general issues which are of concern to us. The first issue concerns the use of language. Using "the homeless" to refer to individuals is depersonalizing; being homeless is difficult enough without also losing a sense of identity. The substitution of "homeless persons," "homeless individuals," or even "the homeless population" would help considerably. Secondly, we want to re-emphasize that, despite the careful wording around the estimates, the report will leave the impression that significant amounts of ADMS Block Grant money are being spent on services to homeless individuals with alcohol, drug abuse and mental disorders. As stated in the report, roughly 75 percent of local providers receiving ADMS funding provide some level of service to homeless individuals. However, the level of service, and the number of homeless individuals receiving it, could be as little as one outpatient visit to one homeless person in the past year.

We have no specific comments on the recommendations contained in the reports on Medicaid and Supplemental Security Income. We do, however, see these programs as essential components of an overall national strategy for meeting the needs of homeless individuals with ADM disorders. We are prepared to take whatever actions are appropriate to bring about greater cooperation and collaboration between PHS programs serving the target population and Medicaid and Supplemental Security Income.

OIG Recommendations

1. The PHS should provide technical assistance to State and local ADMS grantees and other PHS funded grantees who serve homeless individuals. [The technical assistance provided should include, but not be limited to, the two items specified in Recommendation No. 2 below.]

2. The ADAMHA should issue an advisory letter to all States with the next round of funding. The letter should underscore the importance for ADMS grantees to include the following components in serving homeless individuals with mental health, alcohol, or drug problems:

   - Specialized training ...

   - Memoranda of Understanding or other formal agreements with other agencies in the community. ...

PHS Comment

We concur with the principles underlying these two recommendations. However, we do not believe that the ADMS Block Grant is the appropriate mechanism with which to implement the recommendations. Congress has chosen to target the problems of the homeless population by the passage of the McKinney Act. The McKinney Projects for Assistance in Transition from Homelessness (PATH) is the program which targets the homeless population with dual diagnosis of serious mental illness and substance abuse disorders. The PATH program specifically provides for "staff training, including training of individuals who work in shelter, mental health clinics, substance abuse programs and other sites where homeless individuals require services."

In addition, PHS has provided and will continue to provide a wide variety of technical assistance to recipients of its grants. For example, ADAMHA currently funds several specialized clearinghouses and technical assistance centers dealing with the programmatic needs of homeless individuals with ADM disorders. Also, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) currently administers the Community Demonstration Grant Program for Alcohol and Other Drug Treatment for Homeless

Individuals, and the Cooperative Agreements for Research Demonstration Projects on Alcohol and Other Drug Abuse Treatment for Homeless Persons. These two programs are evaluating the effectiveness of comprehensive service interventions designed to meet the special needs of various subgroups of the homeless population. In addition, the NIAAA supports a number of other research grants that are looking at the relationship of alcohol use and homelessness. These research and research demonstration projects will provide the basis for this technical assistance. The National Institute of Mental Health also administers the McKinney Research Demonstration Program for Homeless Mentally Ill Adults and the Mental Health Research Program on Homeless Individuals.

However, PHS is unable to directly provide technical assistance to local ADMS grantees. We believe that the States are in a better position to develop training for local grantees and to encourage the development of agreements among providers.

Technical Comments

Page i, first paragraph under "BACKGROUND" -- The figures given in this paragraph do not reflect the most recent research. The paragraph should be rewritten as follows:

> Recent research suggests that approximately one-third of the homeless are severely mentally ill, at least 40 percent have problems with alcohol, and an additional 10 percent abuse other drugs. In addition, it is estimated that at least one-half of the homeless mentally ill population also have alcohol or other drug problems.

This is also true on page 1 of the introduction, in the second paragraph under "Scope."

Page i, 4th paragraph, last sentence -- It is fairly well established (State Alcohol and Drug Abuse Profile, National Association of State Alcohol and Drug Abuse Directors, 1990) that the ADMS Block Grant, nationally, represents approximately 20 percent of all funding for public sector alcohol and drug abuse treatment services. Accordingly, this information should be used in lieu of the last sentence as it currently reads.

Page i, third paragraph under "BACKGROUND" -- Please change the last sentence to read: "States are not required to specifically serve the homeless population with ADMS monies; however, States may fund services for homeless mentally ill persons and homeless substance abusers."

Page ii, second paragraph under "FINDINGS" -- Please change "problems" to characteristics. The same sentence is in the Table of Contents.

Page ii, last sentence -- After institutionalized persons, please insert "(e.g., in jails and hospitals)."

Table of Contents. The last word of the third finding, "servicese" should be corrected to read "services."

Page 1, second paragraph under "SCOPE" -- Please add after "dually diagnosed" a defining clause, "those individuals with co-occurring mental health and substance use disorders."

Page 2, as noted in the comment for page i, please change the last sentence in the second paragraph to read: "States are not required to specifically serve the homeless population with ADMS monies; however, States may fund services for homeless mentally ill persons and homeless substance abusers."

Page 2, fifth paragraph -- The Task Force on Homelessness and Severe Mental Illness is chaired by the Director of NIMH.

Page 4, the last sentence in the third paragraph needs to be modified. We suspect that the first issue is that the counts were not "unduplicated" and the second issue that respondents were reporting non-ADMS homeless clients (e.g., homeless families).

Page 5, finding No. 2, first paragraph -- Please clarify the "very needy population." Is this a reference to homeless persons with ADM disorders or any homeless person?

Page 6, figure 1 -- Please insert "persons" after homeless. Also, the first bullet needs to be reworked. First, does "stable" home mean permanent housing? Second, should "stable housing" be linked with "drug-free environment?"

Page 7, second paragraph -- We suggest deleting the last two sentences. The first of these sentences, "This was the only...," is unclear, and the second sentence, "the majority of ADMS...," is misleading. The interpretation of these statements could be very different depending on who the actual respondents were. For example, why would line workers know about funding sources (e.g., Federal legislation)?

The final sentence on this page about homeless clients and job skills is too general and should be deleted unless there is more that can be said.

Page 8, first paragraph -- As is, this paragraph has a victim blaming tone, and needs to be toned down. For example, "Follow-through may take more persistence or resources than the life circumstances of homeless persons allow." Consider the life circumstances of a homeless person, and the lack of resources, such as transportation or clocks.

Page 8, figure 2 does not only address homeless persons with ADM disorders. These problems are, however, often particularly relevant to the homeless mentally ill population.

Page 8, fourth paragraph, first sentence -- Please add after "dually diagnosed" a defining clause, "those individuals with co-occurring mental health and substance abuse disorders."

Page 10, first paragraph, first sentence -- This sentence should be revised to read: "This study confirmed earlier findings that homeless individuals..."

Page 10, fourth paragraph, second sentence -- The title for the PATH program is the McKinney Projects for Assistance in

Transition from Homelessness (PATH) program.

Page A2, first sentence -- In the Sampling Methodology section, please clarify who, specifically, were the desired respondents for the sampled "grantees." Were they program managers or clinicians? Did it vary among the 30 grantees?

Page B2. The footnote on the data verification sheet contains a definition that differs from the one provided on page A-3 and is, we suspect, the one that was actually used. The one on page A-3 would appear to exclude those individuals who live on the streets. Both definitions exclude the "at imminent risk" population included in most McKinney programs. Both definitions also include individuals living in transitional housing although they are rarely included in other definitions of the homeless population.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

NOV 22 1991

TO: Richard P. Kusserow, Inspector General

FROM: Assistant Secretary for Planning and Evaluation

SUBJECT: OIG Draft Reports: "Supplemental Income for Homeless Individuals", "Alcohol, Drug Abuse and Mental Health Services for Homeless Individuals", and "Medicaid and Homeless Individuals" 05/91-00060 / OEI-05-91-00062 OEI-05-91-00063

This memorandum provides comments on the three subject draft inspection reports which examined the availability, accessibility and appropriateness of the Supplemental Security Income Program (SSI), the Alcohol, Drug and Mental Health Services (ADMS) block grant, and Medicaid programs for homeless individuals who have mental health, alcohol or other drug problems.

In general, the assessments found that: 1) most ADMS grantees provide some, but usually not specialized, services to homeless people; 2) the type and adequacy of those services are unclear due to the lack of data on the quantity of services or their impact; 3) access to SSI and Medicaid programs is limited although special efforts are now being made by most SSA Field offices to increase access to SSI. Another finding is that most program providers and SSA field office staff recognize that it is especially difficult for the mentally ill or substance abusing population to access SSI and Medicaid programs.

Overall, the findings in these assessments are consistent with what we are learning from other studies and program monitoring, particularly with respect to the need for improved linkage and coordination among different levels of government, between government agencies, and within local service systems. Unfortunately, the data available for these assessments did not allow for more specific findings concerning numbers served, the quality of services provided, or for descriptions of successful, generalizable models.

Nevertheless, the findings and recommendations from these three assessments will help shape a current initiative to simplify programs and make them more accessible to severely mentally ill homeless individuals. Your staff has already briefed the Federal Task Force on Homelessness and Severe Mental Illness and its outside Advisory Committee regarding these assessments. The Task Force will recommend a plan of action to the Secretary by the end of January, 1992.

I have a few additional comments listed below and editorial comments written in the attached copies of these reports.

Alcohol Drug and Mental Health Services for Homeless Individuals

- The background section on page i should include a sentence or two in the discussion of the McKinney Act programs, on the Projects for Assistance in Transition from Homelessness (PATH) program, its purpose, and a clarification that while states award most of their PATH funds to ADMS grantees, those funds are not included by grantees that report providing services to the homeless mentally ill.

- A statement in the background section indicates that the ADMS dollars spent for substance abuse treatment as a portion of state expenditures for this purpose is unknown. We understand that as of 1990, there is an indicator in the National Drug and Alcohol Treatment Utilization Survey that provides this information.

- In the findings section on page 4, the third paragraph under finding #1, this statement should be reworded to clarify that the dollars referred to go to grantees that use an unknown but probably small portion of their grants to serve this population. One could interpret the current statement to mean that over 70% of their block grant funds serve this population.

- Appendix A, pages 4 and 5 contain very low percentages for New York state ADMS funds that go to grantees serving the homeless, and the extent to which ADMS grantees in New York state seek Medicaid reimbursement for services. These estimates are so at odds with those for other states in the sample and with New York's usual participation in such programs that you may wish to re-check them.

Supplemental Security Income and Medicaid for Homeless Individuals

- The same data issue concerning New York state described above for Appendix A of the ADMS Report applies to Appendix A of the reports on SSI and Medicaid as well.

- On page iii of the Executive Summary, we suggest adding a recommendation to ensure that a national survey of the homeless population being planned for 1992/1993 include the proportion receiving SSI benefits.

- The description of the targeted federal response to homelessness on page 1 of all three reports would be more complete with the addition of the following sentence after the second sentence of the fourth paragraph: "An additional $200 million in non-McKinney federal funds is targeted at the homeless population." Total spending in these targeted programs will rise to over $1 Billion in FY 1992.

Martin H. Gerry