Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

COMMUNITY MENTAL HEALTH CENTERS AND HOMELESS PERSONS

JUNE GIBBS BROWN
Inspector General

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OEI-07-95-00061

OFFICE OF INSPECTOR GENERAL

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To obtain a copy of this report, call the Kansas City regional office at (816) 426-3697.

EXECUTIVE SUMMARY

PURPOSE

To determine the extent that community mental health centers serve homeless persons.

BACKGROUND

The homeless population is a heterogenous group of men, women and children who have a variety of health care problems, including a high incidence of mental illness and substance abuse/alcohol disorders.

Community Mental Health Centers (CMHCs) are a major component of health care services for people who are economically disenfranchised and homeless. The centers' primary objective is providing mental health services to persons with mental illness or emotional disturbances. They provide a broad range of services, including individual and group counseling, psychosocial rehabilitation, therapeutic education, life skills training, day programs, and substance abuse counseling and treatment. CMHCs also typically provide case management, medication management, and arrangements for residential services.

This report is based on a mail survey of 50 community mental heath centers and 86 homeless shelters. Fifteen of the 50 centers had received special grant funding to specifically engage in outreach services for homeless persons with mental illness (e.g., the Projects for Assistance in Transition from Homelessness [PATH] grant program or the Access to Community Care and Effective Services and Supports [ACCESS] grant program.) We also conducted on-site visits with two CMHC mental health care managers and five directors of homeless shelters to supplement information from the surveys.

This study was requested by the Assistant Secretary for Planning and Evaluation as part of a broader effort to look at mainstream Federal programs addressing homeless persons.

FINDINGS

Community Mental Health Centers Perform Outreach to Homeless Persons

All centers with PATH and/or ACCESS grants report that they conduct outreach by sending staff or volunteers off-site to areas where homeless persons with mental illness may congregate. However, only 50 percent of those centers which did not receive any PATH or ACCESS funding perform outreach.

Nearly all of the centers' staffs that conduct outreach go to emergency homeless shelters. Outreach staff visit and provide referrals at transitional shelters, street locations, soup kitchens, drop-in centers, parks, depots, and campgrounds. Approximately one-fourth also may go to county jails, public libraries, river banks, psychiatric hospitals, churches, restaurants, and shopping malls.

Centers Receive Referrals from a Variety of Sources

Although 21 percent of the centers' homeless clients with mental illnesses are self-referrals, the majority of homeless clients are referred from emergency shelters, hospital emergency rooms, police, state psychiatric hospitals, and the jail/court system. Only 17 percent (15 of 86) of the homeless shelters report that they do not refer their clients to the CMHCs for mental health services.

A Majority of Shelters Rate their Relationship with Community Mental Health Centers as Positive; Some Problems Do Emerge, However

Over 69 percent of the homeless shelters rate their relationship with the local mental health center as either satisfactory or excellent. However, 20 percent believe that the quality of mental health services at the centers is unsatisfactory or poor. They cited: weakness in providing immediate crisis intervention services; not enough individual therapy; shortage or lack of assignment of case managers and therapists; and clients being given standard prescribed medication without really being listened to.

Centers Provide Referrals for Other Health Care and Social Services

Most centers report providing referrals for other health care services such as substance abuse services, inpatient psychiatric services, medical outpatient services, and referrals for medical assistance benefits/entitlements and programs such as Aid to Families with Dependent Children and Food Stamps.

Centers Cite Barriers in Providing Services to Homeless People, Especially Difficulties in Continuity of Care and Availability of Services in the Community

Community mental health centers report that they face barriers in trying to serve homeless persons, especially since many of those persons with mental illness are also substance abusers. Over one-half of the homeless shelters also responded that clients have problems accessing center services. Barriers include the clients' inability or unwillingness to follow through on a plan of care and shortage of necessary services for homeless persons with mental illness.

OPPORTUNITIES FOR IMPROVEMENT

Overall, community mental health centers and homeless shelters seem to be coordinating their efforts to help homeless people. However, there are still opportunities for improvement. We recognize that resources are limited and that not

all services that are needed can be provided within current funding levels. We offer the following suggestions to centers wishing to re-examine and prioritize their programs for serving homeless persons with mental illness.

Improve Communication and Information Sharing with Homeless Shelters

Communication and information sharing could take the form of periodic meetings to discuss problem areas, beneficial activities, statistical reporting techniques, and the joint monitoring of homeless persons with mental illness. Centers which do not engage in outreach activities could do so; those centers which already do could develop even more assertive outreach programs. Also, community mental health centers could work with homeless hotlines in their service area to provide urgent care or crisis intervention for those needing immediate attention.

At the Federal level, the Substance Abuse and Mental Health Services Administration (SAMHSA) could be instrumental in supporting further research on the topic of homeless persons with mental illness and their difficulties in obtaining appropriate mental health care and counseling.

Offer Comprehensive Services to Address Individual Needs

Counseling services could be offered to specifically address individual needs. These could include: substance abuse counseling (since many clients have a dual-diagnosis of mental illness and substance abuse) and physical and/or sexual abuse counseling. Centers could provide more intensive case management to members of this population. CMHCs could also work with housing programs to develop a variety of housing options.

AGENCY COMMENTS

We received formal comments from the Administrator of SAMHSA and the Assistant Secretary for Planning and Evaluation. Both agreed with the findings in the report. The Administrator of SAMHSA emphasized the need to work more closely with shelters and housing providers and for more research on homelessness and mental illness. Copies of the full text of their comments are included in Appendix A.

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INTRODUCTION

PURPOSE

To determine the extent that community mental health centers serve homeless persons.

BACKGROUND

The homeless population is a heterogenous group of men, women and children. They include long term street dwellers, residents of homeless shelters and temporary living quarters, the economically disadvantaged, single men and women, families with children, as well as runaway and castoff youths. Homeless individuals have a variety of health care problems, including a high incidence of mental illness and substance use/alcohol disorders.

Community Mental Health Centers (CMHCs) are a major component of health care services for people who are economically disenfranchised and homeless. The centers' primary objective is providing mental health services to persons with mental illness and persons with emotional disturbances. They provide a broad range of mental health services, including individual and group counseling, psychosocial rehabilitation, therapeutic education, life skills training, day programs, and substance abuse counseling and treatment. CMHCs also typically provide case management, medication management, and arrangements for residential services.

Public Law 102-321, the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act, mandates a vigorous Federal leadership role in mental health services delivery and policy development. The Act significantly increases the attention and resources devoted to the mental health service needs of children and adults. The Center for Mental Health Services (CMHS) in the Substance Abuse and Mental Health Services Administration (SAMHSA) works closely with other Federal agencies whose programs and policies affect the lives of persons with mental illness. The CMHS also works closely with State and local governments and the private sector to assure continuity, integration of services, and access to comprehensive systems of care.

The CMHS provides national leadership to (1) ensure the application of scientifically established findings and practice-based knowledge in the prevention and treatment of mental disorders; (2) improve access, reduce barriers, and promote high quality effective programs and services for people with, or at risk for these disorders, as well as for their families and communities; and (3) promote the rehabilitation of people with mental disorders. It also composes and retains a listing of all community mental health centers. While having no direct administrative control over mental health center services, the agency compiles statistical information on the facility location, telephone numbers, services available, and years of operation of all centers nationwide.

The Stewart B. McKinney Homeless Assistance Amendment Act of 1990 authorized a new Federal grant program to deal with the needs of people who are homeless and have serious mental illnesses. The program--known as Projects for Assistance in Transition from Homelessness (PATH) --funds community-based outreach, mental health, substance abuse, case management and other support services, as well as a limited set of housing services. Each year, the PATH program distributes about $30 million through formula grants to each State and U.S. territory to provide services to people with serious mental illnesses, including those with co-occurring substance use disorders who are homeless or at risk of becoming homeless. In many States, PATH funds are the only Federal dollars available for outreach services within the mental health system.

Beginning in fiscal year 1993, the Department of Health and Human Services (in collaboration with the Departments of Housing and Urban Development, Labor, Education, and Veterans Affairs) provided Access to Community Care and Effective Services and Supports (ACCESS) grants to nine States. This innovative interdepartmental demonstration project integrates housing, treatment and support services for homeless persons with mental illness. The ACCESS initiative flows directly from the work of the Federal Task Force on Homelessness and Severe Mental Illness and is founded on the assumption that the integration of fragmented services will substantially contribute to ending homelessness among persons with severe mental illness.

METHODOLOGY

The inspection focused on the extent of outreach and services provided by community mental health centers to the population of homeless persons with mental illness. There are approximately 3,000 community mental health center providers nationwide. However, we focused on 569 centers that had previously received Federally funded construction grants, a subset of the "1995 Mental Health Directory" issued by the Survey and Analysis Branch of the Center for Mental Health Services. Since Federally grant-constructed centers constitute only a fraction of community mental health centers nationally, our findings would not be considered representative of all centers, only those which received Federal funding.

We purposefully excluded mental health centers located in cities with populations of 30,000 or less because most rural centers do not have homeless shelters in their service area. From this revised universe, we selected a random sample of 75 centers. In addition, we also selected two - three homeless shelters in the 75 cities in which the community mental health centers are located.

We mailed surveys to 75 CMHCs, and received 50 responses. In addition, we sent surveys to 180 homeless shelter directors and received 86 completed surveys. Due to incomplete response rates, we did not always receive a returned survey from centers and shelters in the same area. The survey document did not make a distinction between access to mental health services by homeless persons with serious mental

illnesses and access by those homeless persons with mental health needs but who do not have a serious mental illness.

We received surveys from:

15 CMHCs with PATH and/or ACCESS grants.
11 CMHCs that are located in cities receiving PATH or ACCESS grants.
24 CMHCs which had no PATH or ACCESS funding.

The inspection team analyzed the responses to the survey questions. These responses were quantified to determine such issues as the number of mental health centers that provide outreach services, the quantity and type of referrals for mental health care treatment and counseling for homeless persons with mental illness, and the extent of barriers that prevent access to services. We also conducted on-site visits with two CMHC mental health care managers and five directors of homeless shelters to supplement information from the surveys.

The characteristic center in our sample was a moderate to large-sized multi-service center established in 1971 with a budget of $8.8 million, and seeing an average of nearly 5,000 unduplicated persons/users annually. There were about 224 homeless persons with mental illness served annually out of a self-reported (estimated) 2,000 homeless persons in each service area. While homeless persons with mental illness comprise about 4-5 percent of the centers' average user population, approximately only 1 percent of the average center's annual budget goes toward operating costs for serving homeless persons and conducting homeless outreach.

This study was requested by the Assistant Secretary for Planning and Evaluation as part of a broader effort to look at mainstream Federal programs addressing homeless persons. This report is one of two related national reports on health care services for the homeless. A companion report addresses the extent that Federally-funded Community Health Centers serve the homeless population.

We conducted our review in accordance with the ***Quality Standards for Inspections*** issued by the President's Council on Integrity and Efficiency.

FINDINGS

Community Mental Health Centers Perform Outreach to Homeless Persons

All centers with PATH and/or ACCESS grants report that they conduct outreach[1] by sending staff or volunteers off-site to areas where homeless persons with mental illness may congregate. However, only 50 percent of those centers which did not receive any PATH or ACCESS funding report performing outreach. Nearly all of the centers' staffs that conduct outreach go to emergency homeless shelters. Outreach staff visit and provide referrals at transitional shelters, street locations, soup kitchens, drop-in centers, parks, depots, and campgrounds. Approximately one-fourth also may go to county jails, public libraries, river banks, psychiatric hospitals, churches, restaurants, and shopping malls.

The most frequent outreach activity is a mental health assessment. This is followed by offering information on mental health services available to shelter residents, providing general health care services, providing food/clothing, and conducting mental health training for shelter staff. Outreach services also cited by mental health centers include referrals to public assistance entitlements, housing assistance, psychiatric referrals, and transportation to psychiatric or medical appointments.

While our respondents reported a varied practice among community mental health centers in providing outreach, 32 percent of the centers conduct daily outreach and 10 percent conduct weekly outreach. Twenty-two percent reported a variety of responses: that they either perform outreach as needed, on a biweekly basis, or 2-3 days per week.

Centers Adapt Screening Protocols to Address Homelessness Issues

Nearly one-half (48 percent) of the mental health centers surveyed report they have adapted treatment and screening protocols to specifically meet the needs of homeless persons with mental illnesses. As part of this effort, emphasis is made to obtain the homeless status during the initial intake process. For instance, over three-fourth's (76 percent) of the centers indicated they identify the housing/homeless status of new clients. Centers also perform comprehensive psychosocial assessments and discuss the housing status in the screening process.

Of the centers reporting treatment recipient figures, nearly five percent of the mental health user population were homeless. From survey data, centers present a picture of

[1]For purposes of this inspection, we defined outreach as: "an initial, continuing, and persistent effort to establish a trusting relationship essential in engaging, connecting, or reconnecting homeless individuals to needed health, mental health, social welfare, and housing services."

homeless persons with mental illness that they serve. Some of the more interesting factors of the homeless client are noted in percentage data:

75% are between 20 - 44 years old.
71% are male.
47% have no insurance. In addition:
33% receive Medicaid;
15% have either Medicare, Veterans or other;
4.5% are self-pay clients; and
0.5% are privately insured.
32% live at shelters; 27% live on the streets;
17% live with family or friends; 10% live in transitional housing; 7% other; and the remaining 7% Unknown.

Centers Receive Referrals from a Variety of Sources

Although 21 percent of the centers' homeless persons with mental illnesses are self-referrals, the majority of homeless clients are referred from emergency homeless shelters, hospital emergency rooms, police, state psychiatric hospitals, and the jail/court system. While 17 percent, or 15 shelters, indicated they do not refer to centers, the majority (or 83%) of the homeless shelters surveyed said that they refer their clients to the centers for mental health services. In addition, the shelters also refer to hospital emergency rooms, substance abuse counseling, homeless outreach counselors, psychiatric social workers, medical clinics, hospital inpatient/outpatient, volunteer psychologists, and private psychologists and psychiatrists.

A Majority of Shelters Rate their Relationship with Community Mental Health Centers as Positive; Some Problems Do Emerge, However

Over two-thirds (69 percent) of the homeless shelters rate their relationship with the local mental health center as either satisfactory or excellent. Only 13 percent report poor working relationships. (Eighteen percent did not respond or indicated that it was not applicable.)

As a function of this relationship, two-thirds (67 percent) of the homeless shelter respondents report they receive positive comments about good or excellent quality of care from homeless persons with mental illness that were referred to community mental health centers. Homeless shelter directors said they receive a diversity of comments from homeless people depending on the client's willingness to receive help. One shelter director said, "The comments are highly subjective and entirely anecdotal. Many clients like their individual case workers but are frustrated by the slow, incremental changes in their lives." A homeless shelter director noted, "(Clients)...appreciate the case management support...(They) feel that staff really care

about their needs/issues...(They) appreciate the opportunity to receive services in a non-threatening setting." Another director indicated that "Clients are grateful to know they are not unique or strange....Appreciate transportation...(The program is)...very effective in working through crisis and long-term depression."

However, 20 percent of homeless shelters believe that the quality of mental health services at the centers is unsatisfactory or poor. They cited: weakness in providing immediate crisis intervention services when homeless people are most vulnerable and willing to accept help; not enough individual therapy to address their problems; shortage or lack of assignment of case managers and therapists; and clients being given standard prescribed medication without really being listened to.

Other concerns enumerated by homeless shelter directors follow:

> "Center appointments are given too many days ahead and the client may need immediate service or may no longer be at the shelter on the appointment day."
>
> "It takes too long to get an appointment.....Clients cannot understand forms.....Clients cannot afford the sliding fee scale....."
>
> "Clients do not understand why their cases are closed...Clients do not receive any follow-up services once placed in housing....Clients do not know where to go or who to ask for help when they start to decompensate."

Centers Provide Referrals for Other Health Care and Social Services

Most centers report providing referrals for health care services. The main referral is to detoxification or other substance abuse services, followed by inpatient psychiatric services. Common referrals also include medical outpatient services provided at such locations as free health clinics and public health clinics. The least common referrals are for dental services at Community Health Centers, residential services, emergency room treatment and services, and medical inpatient treatment. Centers also provide referrals for health care benefits/entitlements:

94% refer to Medicaid.
80% refer to Medicare.
78% refer to Veterans Admin
38% refer to Other programs:
- county relief
- social services
- city nursing
- other clinics

Ninety-four percent of the centers link those who qualify with assistance administered by the Social Security Administration. Centers also offer a full-range of other public assistance referrals:

- 88 percent offer Food Stamp referrals.
- 80 percent refer clients to the AFDC program.
- 70 percent refer clients to the WIC program, if applicable.
- 64 percent refer homeless persons with mental illness to general assistance.
- 24 percent refer to State disability, unemployment compensation, housing agencies, legal assistance, and food banks.

Centers Cite Barriers in Providing Services to Homeless People, Especially Difficulties in Continuity of Care and Availability of Services in the Community

Although 64 percent of community mental health centers conduct an outreach program, centers report that they face barriers in trying to serve homeless persons, especially since many of those persons with mental illness are also substance abusers. Barriers include the clients' inability or unwillingness to follow through on a plan of care and their unwillingness to go to a mental health center for services. Another obstacle listed by many centers is the shortage of necessary services for homeless persons with mental illness.

Over one-half (58 percent) of the homeless shelters reported that clients have problems accessing the centers' services. Most of the items cited are well-known obstacles among the homeless population: lack of affordable transportation; lack of information about center services; and an unwillingness to go to a center for mental health services.

Another problem identified by homeless shelters is that community mental health centers often target their services to those most in need and may not accommodate persons with mental health needs who are not among the most seriously impaired. In addition, centers may find that one problem is that once the client's appointment day arrives, homeless persons have often moved on to another location or shelter.

Also, homeless persons with mental illness located in cities which share State or county lines often find themselves positioned out of the appropriate center's jurisdiction or service area. One shelter responded, "Illinois residents cannot be seen in an Iowa mental health center except for emergencies....." The non-evening, non-weekend hours of some centers were also noted to impact homeless persons with mental illnesses.

OPPORTUNITIES FOR IMPROVEMENT

Overall, community mental health centers and homeless shelters seem to be coordinating their efforts to help homeless people. However, there are still opportunities for improvement. We recognize that resources are limited and that not all services that are needed can be provided within current funding levels. We offer the following suggestions to centers wishing to re-examine and prioritize their programs for serving homeless persons with mental illness.

Improve Communication and Information Sharing with Homeless Shelters

Communication and information sharing could take the form of periodic meetings to discuss problem areas, beneficial activities, statistical reporting techniques, and the joint monitoring of homeless persons with mental illness. Centers which do not engage in outreach activities could do so; those centers which already do could develop even more assertive outreach programs. Also, community mental health centers could work with homeless hotlines in their service area to provide urgent care or crisis intervention for those needing immediate attention.

At the Federal level, SAMHSA could be instrumental in supporting further research on the topic of homeless persons with mental illness and their difficulties in obtaining appropriate mental health care and counseling.

Offer Comprehensive Services to Address Individual Needs

Counseling services could be offered to specifically address individual needs. These could include: substance abuse counseling (since many clients have a dual-diagnosis of mental illness and substance abuse) and physical and/or sexual abuse counseling. Times for such sessions might need to be flexible to deal with the clientele's inconsistency in keeping appointments. In addition, counselors could proactively work with the homeless client, stressing the importance of continual therapy to achieve progress.

Centers could provide more intensive case management to homeless persons with mental illnesses. These services could be provided on an ongoing basis in order to engage homeless persons with serious mental illnesses into mental health services, obtain housing, entitlements and mainstream services on their behalf, and help them establish residential stability.

Centers could work with housing programs to develop a variety of housing options. However, providing housing is not enough. Many homeless persons with mental illness need intensive, on-site support to maintain their residential stability. Centers could provide supportive services to homeless individuals in their housing to help them achieve that stability.

AGENCY COMMENTS

We received formal comments from the Administrator of SAMHSA and the Assistant Secretary for Planning and Evaluation. Both agreed with the findings in the report. The Administrator of SAMHSA emphasized the need to work more closely with shelters and housing providers and for more research on homelessness and mental illness. Copies of the full text of their comments are included in Appendix A.

APPENDIX A

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Substance Abuse and Mental
Health Services Administration
Rockville MD 20857

JUL 16 1996

DATE:

TO: Inspector General, DHHS

FROM: Administrator, Substance Abuse and Mental Health Services Administration

SUBJECT: OIG Draft Report: "Community Mental Health Centers and Homeless Persons," OEI-07-95-00061

Attached are the Substance Abuse and Mental Health Services Administration's comments on the subject Office of Inspector General draft report. We appreciate the opportunity to review the report. We believe it provides valuable information about the extent to which Community Mental Health Centers serve homeless persons and look forward to receiving the final report.

If you have any questions regarding these comments, please contact Nancy McGinness on 443-1155.

Nelba Chavez, Ph.D.

COMMENTS OF THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION ON THE OFFICE OF INSPECTOR GENERAL DRAFT REPORT, "COMMUNITY MENTAL HEALTH CENTERS AND HOMELESS PERSONS," OEI-07-95-00061

Thank you for the opportunity to review and provide comments on the subject draft report. It is responsive to our earlier concerns and recommendations. We were not surprised to learn that all of the community mental health centers (CMHCs) in the study that received PATH or ACCESS funding also provided outreach, while only fifty percent of those that did not receive this funding provided outreach. Both the ACCESS and PATH programs have encouraged CMHCs to work more aggressively with the homeless population.

We agree with the suggestions about the need for better communication between CMHCs and shelters, more assertive outreach to people in the shelters, more intensive case management and counseling for persons who are homeless and more housing resources. If the CMHCs are going to have an impact on reducing homelessness, they will need to work more closely with shelters and housing providers.

We also agree that there is need for more research on homelessness and mental illness and that the Substance Abuse and Mental Health Services Administration could be valuable in supporting these knowledge development initiatives. The Center for Mental Health Services (CMHS) has funded a number of research and evaluation studies on homelessness. The McKinney Research Demonstration Program, which was funded between 1990 and 1993, examined the effectiveness of different approaches to providing mental health treatment, housing, and related services to homeless adults who have severe mental illnesses. The Dual Diagnosis Treatment Demonstration Program, funded jointly with the Center for Substance Abuse Treatment (CSAT) between 1993 and 1995, identified and evaluated integrated approaches to treating homeless people with co-occurring mental illnesses and substance use disorders. The ACCESS Program is a 5 year demonstration program, initiated in 1993, to identify effective strategies for creating integrated service systems so that people who are homeless and mentally ill will have immediate access to mental health and substance abuse treatment, health care, housing and income supports and entitltements. Finally, CMHS and CSAT will support in the fall of 1996 a new knowledge development program to document homelessness prevention models for individuals with serious mental illnesses and/or substance use disorders. As the findings from these programs are published, they are providing important information regarding effective services and service delivery to people who are homeless and mentally ill.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

JUL 17 1996

TO: June Gibbs Brown
Inspector General

FROM: Assistant Secretary for Planning and Evaluation

SUBJECT: Comments on the OIG Draft Report: "Community Mental Health Centers and Homeless Persons," OEI-07-95-00061

Thank you very much for the opportunity to review the above referenced report. Knowledge about the extent that community mental health centers (CMHCs) serve the homeless and how such services can be improved is highly important.

The report represents a major improvement over the first draft. We are pleased to see included in the report: people focused, rather than illness and homeless focused language used in describing the population; a definition of outreach; and the note that the survey questionnaire did not make a distinction between persons with serious mental illness and those who do not have a serious mental illness. Most importantly, we were pleased to see the analysis of the outreach data by looking at centers' receipt of Projects for Assistance in Transition from Homelessness (PATH) or Access to Community Care and Effective Services and Supports (ACCESS) funding. As a result of the inclusion of the PATH and ACCESS analysis we are better able to see that both the ACCESS and PATH programs have encouraged CMHCs to work more aggressively with the homeless population.

We appreciate this opportunity to review this draft OIG report. We believe it provides valuable information about the extent to which CMHCs serve homeless persons and look forward to receiving the final report.

Peter B. Edelman