

Department of Health and Human Services

OFFICE OF  
INSPECTOR GENERAL

HOMELESS OVERVIEW

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This report was prepared in Chicago under the direction of William C. Moran, Regional Inspector General, Natalie Coen, Deputy Regional Inspector General, and Barbara Butz, Project Leader, Office of Evaluation and Inspections.

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## **PURPOSE**

Based on findings from two Office of Inspector General (OIG) studies on homelessness, this report presents ways in which homeless programs could more strategically focus on long-term solutions to the problem.

## **BACKGROUND**

In 1989, the OIG began a series of inspections on homelessness. This report presents ideas about ways to serve the homeless, especially individuals with alcohol, drug or mental health problems, which expand upon the findings of two of these inspections. It does not address findings from other OIG studies on homeless families.

The first of these inspections, entitled "State and Local Perspectives on the McKinney Act," revealed that the McKinney Act had helped increase awareness about homelessness and made more services available, but that respondents looked to Federal mainstream programs for a solution to the problem. The second study, to be finalized shortly, examined the extent to which three Department of Health and Human Services (HHS) mainstream programs serve homeless individuals with alcohol, drug or mental health problems.

These studies highlighted the fact that the problems of such homeless individuals are more desperate, severe and difficult to treat than those of non-homeless clients. They also identified many barriers that stand in the way of effective service delivery to them: the complexity and fragmentation of the service system; their need for many, varied services; their transient lifestyle; and other personal characteristics such as peculiar appearance or behavior, fear or paranoia about the service system, and an inability to follow through without assistance.

In this report, we discuss four components that we have come to believe should be part of any broad-based strategy to combat homelessness, whether at the Federal, State or local level. They were mentioned repeatedly in our reading and discussions with hundreds of policy-makers, planners, administrators, advocates, and service providers. Two of them relate to service delivery: outreach/assessment and case management. McKinney-funded and mainstream providers alike recognize that homeless individuals need special approaches to service delivery such as these to help them overcome the barriers mentioned above. The other two components relate more broadly to programs or systems: linkage/coordination and data collection/evaluation.

We also present some options for ways to incorporate these components in strategic plans and services. Many options relate to the McKinney Act. We believe that the McKinney Act's most effective role has been as a catalyst: encouraging information exchange, funding research and new methods of service delivery, providing training and technical assistance, and bringing people from many disciplines together to examine

issues and strategize solutions. As our respondents recognized, McKinney Act funding alone cannot lead to a solution; but, it can help States and localities improve their response to the homeless in a more strategic way.

The options we present are neither exhaustive nor "magic bullets." We know that a host of agencies and approaches is needed to achieve a solution for such a heterogeneous population with so many different, severe, and chronic problems. Our emphasis in suggesting them is to encourage pragmatic actions which will begin to show results in a short time, perhaps as little as 1 to 2 years.

## STRATEGIC COMPONENTS

### *1. Outreach/Assessment*

*Few providers who serve homeless individuals systematically conduct both outreach and assessment, as one process.*

Both the literature and our discussions with respondents drive home the importance of outreach to the homeless, especially those with alcohol, drug, or mental health problems. Outreach is an important service in some McKinney-funded programs, such as Health Care for the Homeless (HCH) and Projects to Aid the Transition from Homelessness (PATH). Yet we found that mainstream providers - treatment providers, welfare offices and Social Security district offices - rarely do systematic outreach to the homeless. Thus many homeless individuals may never receive the services they so desperately need to stabilize their lives.

Much of the literature on this population also emphasizes the importance of assessment. However, we believe that few providers, even McKinney-funded providers, are doing systematic, in-depth assessment. Of course, assessment can be expensive and difficult, requiring considerable expertise, time, and patience. Yet, problems that are not accurately identified may not be addressed. Clients may cycle repeatedly through the emergency system without getting help that holds some potential for long-term stabilization. As an example, we heard respondents speculate that some of their clients are developmentally disabled (mildly retarded), but that they have never been tested and the extent of the problem is unknown. Surely such a problem must be diagnosed if any service plan is to be effective.

### Options

- ▶ Use McKinney Act funds to support multi-disciplinary teams to conduct outreach and assessment as one process in programs such as PATH, HCH, and veterans' programs. Such teams are particularly critical for the severely mentally ill and the dually diagnosed, that is, people with both alcohol or other drug problems, and mental illness. The process of "engagement" alone for such people, that is,

overcoming fear and building trust, can take much time, dedication and expertise. In this kind of approach, team members can bring a wide variety of expertise to bear on a broad spectrum of problems, as well as support each other in dealing with very difficult clients.

- ▶ Fund short-term (1 or 2 year) service demonstrations to develop and test outreach methodologies, assessment techniques, and diagnostic tools. In HHS, this could be done by the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA). The emphasis should be on what is effective yet not overly costly or burdensome for providers. The techniques developed may not be perfect or as comprehensive as some might like, but they should offer more guidance than currently exists to providers. In terms of assessment, we are not convinced that it is cost effective to mandate extensive assessment until there is more information on the effectiveness of various methodologies and their cost.
- ▶ Use the Interagency Council on the Homeless and the PATH program to provide training and technical assistance to States and providers (both McKinney-funded and mainstream programs) on outreach and assessment techniques.
- ▶ Use the National Health Service Corps to provide psychiatrists as part of outreach and assessment teams working with the severely mentally ill and dually diagnosed homeless, or to conduct assessment in shelters, day centers or other sites where the homeless congregate.

## *2. Case Management*

*Case management is a key component in a solution to homelessness. For many reasons, however, case management seems to be more the exception than the rule in homeless programs.*

It is clear to us that case management is increasingly regarded as a key component of assistance for many homeless individuals, especially those with alcohol, drug or mental health problems and the dually diagnosed. Our impression is that, while there is no single, universally accepted definition of case management, many subscribe to this central concept: a case manager is a person who works with a homeless client over time to develop a coordinated plan of service including housing, income, and support services, and who helps the client negotiate the service system. Some people we talked to also believe that a case manager should follow up after clients find housing, to make sure they continue to get the supportive services they need.

We believe that little case management of this sort is occurring, even in homeless programs. Perhaps this is not so surprising; many providers lack the resources to meet even the most basic needs of their homeless clients for shelter and food, much less to provide case management, which is expensive, time-consuming, and requires great dedication and expertise.

We advocate a push to expand the use of case management with this population. We think that this should be accomplished primarily through programs such as those funded by the McKinney Act. This is because mainstream providers are already spread thin trying to serve a much broader clientele and cannot realistically be expected to take on case management for the homeless alone.

### Options

- ▶ Provide a definition of case management under the McKinney Act which emphasizes the provision of on-going support and linkage to all services: housing, income, and support services.
- ▶ Make case management a required component of PATH, HCH, and McKinney-funded veterans' programs, which serve some of the most "hard-core" homeless: the severely mentally ill, those with alcohol or other drug problems, and the dually diagnosed.
- ▶ Where appropriate, Federal administrators in mainstream (non-McKinney-funded) programs should emphasize to States or providers that case management for the homeless is an allowable service. In HHS, such programs could be the Social Services block grant or the Community Services block grant.
- ▶ Evaluate different models of case management, the outcomes associated with them, and their costs, with the goal of identifying cost-effective models for this population. In HHS, this could be done by the Assistant Secretary for Planning and Evaluation (ASPE) in conjunction with the Public Health Service (PHS).
- ▶ In States that fund targeted case management under Medicaid to serve the homeless, evaluate its impact on reducing hospitalization for the homeless mentally ill, recidivism in the criminal justice system, and their use of health services or other services in general. This could be done in HHS by ASPE, in conjunction with the Health Care Financing Administration and PHS.

### 3. *Linkage/Coordination*

*Coordination remains much more focused on sharing information than on formal linkages for planning and service delivery.*

In both studies, we found that the term "coordination" in most places was synonymous with information-sharing rather than planning or service delivery. In the States we sampled, we found little evidence of coordinated strategies in order to link State agencies to address homelessness. At the local level, we found that formal linkage between providers, McKinney-funded and mainstream, to serve the homeless was the exception rather than the rule.

We recommended that there be much greater emphasis on developing formal linkages between programs and services in the areas of planning, service delivery, and evaluation. This theme is echoed in the literature and was also mentioned by many of our respondents, who recognize that for many highly dysfunctional homeless individuals, no single service or provider alone will be effective. Thoughtful, coordinated effort between providers is critical to help them receive all the services they need from a complex and highly fragmented service system.

In this report, we are advocating a stronger push for formal linkage between housing providers, health/social service providers, and three other service systems which also deal with high numbers of homeless individuals. The first of these systems is veterans' programs; in many cities, veterans are a high proportion of the homeless population. The second is State mental hospitals, where many of the severely mentally ill homeless end up repeatedly; pre-release plans developed here should be a vehicle to plan coordinated services, including housing and income support. The third is the criminal justice system - courts and jails - since many homeless also land here, where they receive few rehabilitative services and may be released without money, housing, or social supports.

We also believe that more systematic, effective information exchange is needed on the homeless population itself, as well as on service delivery techniques. There are success stories, yet few providers we talked to knew what others outside their communities were doing. They are anxious for information on different service delivery techniques in general, and their effectiveness. In our view, information-exchange of this kind is one of the most important and appropriate roles that the Federal Government can play.

### Options

- ▶ Under the auspices of the Interagency Council on the Homeless, subsidize a national clearinghouse to disseminate information broadly and at reasonable cost throughout the homeless network, to mainstream providers, researchers and academics, advocates, and others.
- ▶ Use McKinney Act funds, or training/technical assistance funds in other mainstream Federal programs, to subsidize regional training centers for McKinney-funded and mainstream providers, to provide training on planning, service delivery techniques, coordinated service delivery, and data collection/evaluation techniques relative to services to the homeless.
- ▶ Establish agreements between Federal agencies (HHS, the Department of Housing and Urban Development, the Department of Veterans' Affairs, the Department of Justice) to develop models of linkages between their providers at the local level.
- ▶ Require State formula grant programs in HHS to include in their plans a description of the needs of the homeless population and a strategy for addressing them. Require that these plans be coordinated with each State's Comprehensive Housing Affordability Strategy (CHAS), required under the McKinney Act.
- ▶ Establish a task force in HHS to promote coordination between PHS programs that serve the homeless. At a minimum, members would include the Office for Treatment Improvement (OTI), the Division of Applied and Services Research, the Office of Programs for the Homeless Mentally Ill, and the Bureau of Health Care Delivery and Assistance. The task force could undertake: information-sharing about their programs, cross-training of staff, technical assistance to one another, coordinated review of plans addressing homelessness, and development of model programs to serve the homeless.
- ▶ In HHS, use PHS/OTI special grants programs (target cities, special populations, for example) to fund demonstration grants that test linkages between different systems (health, social service, housing, income support) for serving homeless individuals.
- ▶ Use PHS Commissioned Corps personnel in 2-year assignments to work in health care programs, including mental health and substance abuse programs, that serve the homeless.
- ▶ Require that McKinney Act grantees, as a condition of funding, show evidence of participation in a community strategy to address homelessness, through a local planning body of some sort, if one exists.

- ▶ Require that McKinney Act grantees, as a condition of funding, provide evidence of formal linkages, with special emphasis on linkages between housing programs, veterans' programs, the criminal justice system, State psychiatric hospitals, and other mainstream social service, income, and employment providers.
- ▶ Use McKinney Act funding to support coordinator positions at the service delivery level. Require coordinators to establish formal working agreements between McKinney-funded and mainstream providers, and between different service systems, such as housing, health care and treatment, income support, and support services.
- ▶ Use McKinney Act funding to support multi-disciplinary continuous treatment teams in PATH, HCH and McKinney-funded veterans' programs. Teams would do outreach and assessment, case management, follow-up and support once clients are stabilized or placed in housing.

#### *4. Data Collection/Evaluation*

*Few providers systematically collect data on their homeless clients or evaluate the outcome of their programs.*

We believe that the absence of reliable data in most programs is a serious shortcoming which should be aggressively addressed. In both studies, we found that systematic data collection - on clients themselves as well as on service outcomes - understandably takes a back seat to service delivery in most programs. Yet without reliable data, programs may be based on inaccurate, unrealistic assumptions and program goals. Thus, scarce resources will not be used efficiently to achieve significant long-term outcomes.

We heard complaints from some McKinney-funded respondents that the program goals - the criteria for "success" - required of them are not realistic for some of their clients. For example, we heard that goals should be expressed as outcomes, not simply numbers served; this would more realistically reflect the extraordinary time and effort it takes to serve homeless individuals. And, we heard that goals should be expressed in terms of stabilization for some clients who are too impaired to be fully rehabilitated; end-stage alcoholics and the severely mentally ill were two examples given of such clients.

Of course, data collection and evaluation cost money, and we heard from many providers that they prefer to spend scarce funds on services, given the urgent immediate needs of the homeless. Nevertheless, we believe that in the long run, more complete and better quality information will lead to more realistic plans and better targeting of services.



While we advocate a harder look at this issue, we are not convinced that it would be cost effective to mandate extensive data collection and evaluation across the board, in every program or every State. Instead, we present options which are narrower in scope, until such time as more is known about effective techniques and methodologies.

### Options

- ▶ Fund short (1 or 2 year) research demonstrations to develop and test data collection techniques, program evaluation techniques, and outcome measurements. The emphasis should be pragmatic: what works but is not overly costly or burdensome. The methodologies identified may not be as perfect or comprehensive as some might like, but they should offer more guidance than currently exists to providers. In HHS, this option could be undertaken by ASPE in conjunction with the Operating Divisions (OPDIVs) that have programs serving the homeless.
- ▶ Through the Interagency Council on the Homeless, develop simple data collection and self-evaluation tools that homeless providers can use immediately. Provide training and technical assistance to States and providers (McKinney funded and mainstream) on them.
- ▶ Make self-evaluation mandatory for McKinney-funded grantees. Allow 5 percent of total budget for planning and evaluation purposes. Allow it as an in-kind contribution.
- ▶ Conduct focused studies on outcomes and set forth model standards for homeless programs based on these types of outcomes. In HHS, this could be accomplished by ASPE in conjunction with the OPDIVs.
- ▶ Conduct small, focused studies to try to generally document the costs of persons cycling in and out of the emergency services system. Use McKinney-funded grantees to follow people who refuse services, or do not follow through on services, over a 1 year period to trace where they go. Try to generally estimate the costs associated with providing emergency services, incarceration, and institutionalization. In HHS, this could be done by ASPE in conjunction with the OPDIVs.