Enhancing Mental Health Services for Homeless Persons: State Proposals under the MHSH Block Grant Program

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Synopsis

The Mental Health Services for the Homeless Block Grant Program has made available more than $57 million to the States in fiscal years 1987–89 to encourage States to develop and strengthen community services for homeless mentally ill persons. Funds were provided for five basic services, which include outreach, case management, mental health treatment, residential support services, and training for service providers.

State applications for funds reflected considerable diversity among the services proposed. The manner in which States proposed to use the funds is described, including methods used to identify high need areas and distribute funds and plans for delivering services.

ESTIMATES of the number of homeless persons in the United States range from 250,000 to 350,000 up to 3 million persons. The first set of figures represents a daily estimate reported by the Department of Housing and Urban Development in its 1984 national report on the problem of homelessness (*1*). The 3 million figure, extrapolated from local studies, is based on an estimate that annually 1 percent of the population lacks shelter (*2*).

Although a precise estimate of the size of the mentally ill homeless population is not possible (*3*), studies suggest that a third of the homeless population suffers from severe, disabling mental illness (*4*). This subgroup is one of the most poorly served groups in the country. They are frequently excluded from programs designed to serve the general homeless population, while services designed for the severely mentally ill often are inaccessible to them or inappropriate to their needs.

The Stewart B. McKinney Homeless Assistance Act (PL 100–77), enacted July 22, 1987, was the first omnibus legislation providing assistance specifically targeted to the homeless population. The act contains two provisions for the delivery of mental health services to homeless persons. The first is the Mental Health Services for the Homeless (MHSH) Block Grant Program (section 611), which provides States with funds to deliver a required set of community mental health services to those who are either homeless or at significant risk of becoming homeless. States applied for funds by submitting proposals outlining the services they intended to deliver. State applications were reviewed, and in this report we describe the various ways States proposed to use the block grant funds. The MHSH Block Grant Program is administered jointly by the Alcohol, Drug Abuse, and Mental Health Administration and the National Institute of Mental Health (NIMH).

Under the second mental health provision of the act, the Community Mental Health Services Demonstration Program (section 612), NIMH awarded funds to support 12 projects providing comprehensive mental health services to homeless severely mentally ill adults and severely emotionally disturbed children and adolescents. A synopsis of the 12 demonstration projects funded in fiscal year 1988 is available (*5*).

MHSH Block Grants

Congress appropriated $32.2 million for the MHSH block grants for fiscal year 1987. A supplemental appropriation of $11.5 million was provided in fiscal year 1988. Because the fiscal year 1987 appropriation was made late in the year, both 1987 and 1988 funds were awarded at the same time in one allotment. The availability of funds was announced to Governors on September 29, 1987, and States had up to 1 year to apply. State allotments

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were made according to a formula based on the proportion of a State's urban population relative to the urban population of the United States, with each State receiving a minimum of $275,000. States were required to provide non-Federal matching funds of $1 for each $3 provided.

Fifty States, the District of Columbia, and Puerto Rico received funds in fiscal years 1987 and 1988. The combined allotments ranged from the minimum of $275,000 (received by 20 States) to $6,073,586, received by California.

The act was amended on November 7, 1988, extending the block grant authority for an additional 3 years, again specifying a minimum of $275,000 for each State, Puerto Rico, and the District of Columbia. The Territories of Guam, the Virgin Islands, American Samoa, and the Northern Marianna Islands also became eligible, with a minimum allotment of $50,000. Because only $14.1 million was appropriated in fiscal year 1989, funds were insufficient to cover the minimums for the year, and allotments were reduced to $267,944 for States and $48,717 for territories. The amendment specifies that if the appropriation is insufficient to provide each State, the District of Columbia, and Puerto Rico with a minimum of $150,000, the funds will be converted to a categorical grant program, which would require States to apply for funds for specific individual projects.

Providing Required Services

States are required under MHSH block grants to agree to provide a defined set of community mental health services to homeless persons. Although States are required to provide all of the services, all services do not have to be provided at each site. The required services include

- outreach services;
- community mental health, diagnostic, crisis intervention, and habilitation and rehabilitation services;
- referral for hospital and appropriate primary health services and substance abuse services;
- training for outreach workers and those who work in shelters, mental health clinics, and other sites where homeless persons receive services;
- case management services; and
- supportive and supervisory services in residential settings.

Training for those providing services to homeless mentally ill persons is required to include identification of the chronically mentally ill; referral to available services, such as job training, literacy education, community health centers, community mental health centers, and substance abuse treatment programs; and, identification of benefit programs and referral of clients to them.

The required case management services include preparation and review of individual treatment plans at least every 3 months; assistance in obtaining and coordinating social and maintenance services; assistance in obtaining income support, including housing assistance, food stamps, and supplemental security income benefits; referral to other appropriate services; and, under certain conditions, provision of representative payee services for individuals receiving aid under Title XVI of the Social Security Act.

Summary of State Applications

State applications for funds showed considerable diversity in existing services available to homeless mentally ill persons, and wide differences in the States' progress toward developing plans for addressing the needs of this population. While many States submitted specific proposals, others submitted applications describing a range of services they would consider offering with block grant funds. The actual services to be provided would depend upon proposals received from counties or agencies within the State. Therefore, in many cases, applications did not precisely indicate how funds would be used.

Methods used to estimate high need areas. States were required to identify the geographic areas in which the greatest number of homeless mentally ill persons in need of services were located. Wide variations were seen among States in terms of methods for identifying such areas. Some States estimated the number of homeless mentally ill persons in the

State on a given day, while others estimated the number during a 1-year period. Some provided statewide numerical estimates accompanied by a list of the cities or counties with the largest populations; others provided estimates of the number of homeless mentally ill persons for each region, for each city, or for a State's urban areas. Therefore it is not possible to use this information to compare the magnitude of the problem among States.

The most common approach was to estimate the homeless population of an entire State, a region, or a community, and assume that a percentage of those persons were mentally ill. The number of homeless persons was estimated using a variety of methods, including local or statewide surveys of the number of individuals using shelters and other services for homeless persons, and national or State estimates of the homeless population, adjusted to local population rates. Estimates of the proportion of mentally ill homeless persons were based on local studies, studies of other cities within a State, or national estimates. Estimated rates of mental illness among the homeless population ranged from 10 to 70 percent. The operational definitions of mental illness on which these estimates were based differed, and included current diagnosis, history of use of mental health services, current use of mental health services, and "history of mental illness." In some cases the definitions included drug and alcohol abusers, and in other cases they were excluded.

The other widely used method for estimating the number of homeless mentally ill persons in a given area was to survey local service providers. For example, one southern State based its estimate on the number of homeless persons who used mental health and other social services. A New England State took the opposite approach, estimating the proportion of shelter users who required mental health services.

Many State applications noted the lack of good data on which to base local estimates of the size of the homeless mentally ill population. A midwestern State proposed to use part of its funds for local needs assessments to refine its estimates.

Methods used to distribute funds. Although some States proposed to make funds available on a statewide basis, the majority targeted MHSH funds to a limited number of high need areas. High need areas were defined in terms of the number of homeless in the area, the number of homeless mentally ill in the area, or the population density. Some States considered both the homeless population and the availability of services. For example, one State discounted a major metropolitan area from funding because it already had a NIMH demonstration project. At least one State considered the nature of the homeless population, disqualifying one region because the homeless population in that area was highly transient. In most cases the targeted high need areas were cities or urban counties. In a few instances, rural areas with major highway intersections were identified. Several States selected one city to receive all of the funds.

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Most States used some type of request for proposals as a means for distributing funds. In some cases this was a non-competitive process, in which high need regions or counties were identified and invited to apply for funds. For example, a southern State targeted its five most urban counties for receipt of funds. Each county would be invited to submit a proposal and the funds would be divided evenly between the five counties. Other States proposed a competitive request for proposals (RFP) process. The process took such forms as statewide competitive RFPs from regions, counties, or agencies; competitive RFPs from State and nonprofit agencies in high need regions or counties; or competitive RFPs from high need regions or counties.

Some of the judging criteria included the quality of the proposal, plans for coordination with other services, the ability to provide some or all of the designated services, the ability to continue the proposed program when MHSH funds expired, the ability to provide matching funds, and the demonstrated need for services.

Some States distributed funds statewide, either evenly to different service areas, or by using a formula. A western State, for example, based its formula on the population in households with income less than 125 percent of the poverty level, the number of disabled recipients of Federal entitlements, the number of general relief recipients, the amount of unemployment, and county population.

Relation to other State services. In some States, the proposed services were part of a larger State plan for serving homeless persons. MHSH funds would be used to provide specialized mental health services within the broader plan. For example, a western State described a well defined, three-tier plan for serving homeless persons, which emphasized emergency, transitional, and low-cost, permanent housing and support. MHSH funds would be used to enhance services to mentally ill persons within this larger homeless initiative.

Other States proposed to use block grant funds as part of a larger State plan for serving mentally ill persons. Funds would be used to provide special services for homeless persons. A New England State presented a plan to implement Continuous Treatment Teams in each service region. These outreach and case management teams were designed to deliver services assertively to a variety of difficult-to-serve populations. The State would use block grant funds to add one outreach worker, who would specialize in serving the homeless, to each team.

A midwestern State, with a well developed State mental health system, proposed to use MHSH funds to expand and enhance already effective mental health services, in order to better serve homeless persons. Funds also would be used to develop or expand services to link homeless mentally ill persons to existing programs.

A few States proposed to use MHSH funds to enhance existing services for the homeless mentally ill population. A western State had already provided funds for serving homeless mentally ill persons to all counties that had applied. MHSH funds would be used to supplement those services. Counties would be required to increase transitional and permanent housing units as a condition of receipt of funds.

Another State had a program in place to support independent living for homeless mentally ill persons. After diagnosis and stabilization by crisis services or hospitalization, clients were referred for case management and housing assistance. MHSH funds would be used to increase that program by 46 service slots.

Two States proposed to use a portion of their funds to build on existing NIMH demonstration projects. One State would use part of its funds to expand an urban demonstration project. It would establish transitional and long-term residences and expand outreach services and outpatient treatment. A southern State intended to allocate a portion of its funds to an existing demonstration to expand the scope and range of its outreach services and to develop residential and day programs. Many States planned to use funds to provide a new set of services statewide or for particular high need areas.

State plans versus individualized programs. States varied in the extent to which they planned to specialize their services to the needs of individual services areas. Some proposed a State plan in which the same services would be delivered statewide. One State, for example, planned to hire case managers who would specialize in working with homeless mentally ill persons at each community mental health center in the State. As described previously, a New England State proposed a statewide plan of adding outreach workers, who would specialize in the problems of homelessness, to all of its Continuous Treatment Teams. Other States proposed to provide specialized services for different service areas. For example, one southern State planned to fund six programs in five different regions. The programs focused on street case management; outreach to homeless youth; mobile triage; community placement of homeless adolescent girls, using a mentor model; and outreach to adults. Similarly, another southern State proposed four distinct programs, including case management focused on community and hospitalized populations, outreach, case management focused on permanent housing, and case management and staff training to be provided at a single room occupancy hotel.

Services to be delivered. Although a designated set of services were required, States varied widely in how they defined and proposed to deliver services.

Outreach. Several States planned to develop mobile outreach units that would provide services wherever homeless people congregate, such as in parks, on street corners, and in river front areas. The units would be staffed by teams made up of various combinations of service providers, such as social workers, nurse practitioners, case managers, psychologists, psychiatrists, mental health paraprofessionals, and peer outreach workers.

Some States proposed outreach to community sites where homeless persons receive services, such as shelters, soup kitchens, benefits offices, health clinics, and day treatment centers. Other plans focused on outreach to institutions, such as jails and psychiatric hospitals. One State defined outreach as the placement of a drop-in center in an area where homeless persons congregate.

The focus of outreach services also showed diversity. Some States emphasized engaging homeless mentally ill persons in services. For example, one of the outreach programs in a northwest State focused on making contact with homeless mentally ill persons, building rapport, and providing crisis intervention services. Clients would then be referred for case management, counseling, and health treatment at other service sites. Outreach in another State focused on residential placements of homeless persons. Once clients were placed in residential settings, full case management services would be initiated.

Several States proposed onsite service provision as part of the outreach worker's role. For example, one State proposed the delivery of onsite outreach and case management services focused on locating homeless mentally ill clients and assuring their access to needed services and community resources. Another State planned to establish mobile outreach teams to identify, evaluate, and provide services to homeless mentally ill people onsite at shelters, missions, drop-in centers, and transitional housing sites. Specialized outreach services were proposed. One eastern State, for example, planned to develop 24-hour emergency outreach teams based at community mental health centers. The teams would provide onsite crisis intervention at shelters.

Case management. States varied in where they planned to provide case management services. A southern State proposed a program to hire workers who would provide case management services on the street. Programs in one western State also stressed the delivery of services "*in vivo.*" In contrast, a New England State planned to hire workers who would be based in shelters and provide case management services to shelter residents. Another State proposed the use of case managers based at a day program for homeless persons and at a transitional housing agency. Many States planned to provide case management services based at community mental health centers.

While all States were required to provide a designated set of case management services, several States added other functions to the case manager's role, such as facilitating family and consumer education and support, advocacy, transportation, and living skills training.

Training. In most States, proposed training programs were directed toward a variety of professionals who serve homeless mentally ill persons, including shelter workers, mental health workers, other social service workers, emergency room personnel, and the police. In some States training would focus on staff members of the new treatment programs funded under the MHSH Block Grant Program. Training sites varied. In some cases, training would be done at individual agencies. In others, State mental health staff or private contractors would conduct large State or regional training programs. In one instance, the State planned to develop a training protocol to be distributed to different service regions.

While many States planned to provide training for program staff members on the designated content areas, States added to the training programs such topics as characteristics of schizophrenia and bipolar disorders, psychopharmacology, engagement, coordination of services, crisis intervention, interviewing skills, and treatment.

Support and supervision in residential settings. States varied in terms of whether they planned to provide support services to existing residences, or to create new supported residential settings. An eastern State planned a program focused on support and supervision of existing residences, including subsidized apartments, group homes, single room occupancy hotels, and specialized residences. Support services would include rehabilitation, skill building, and vocational services.

Several States planned to use funds for support services in conjunction with new residential programs. For example, an eastern State proposed two county programs in which State community mental health centers would contract with other agencies to provide residential facilities. One county planned to contract with the Salvation Army to run a specialized shelter for mentally ill homeless persons. The other planned to contract with three residential facilities to provide respite beds with varying levels of supervision. The community men-

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tal health centers would then provide support services to the residential facilities.

A southern State proposed to place homeless adolescents in the care of families in the community. The program would be based on a mentor model and would attempt to prepare young women for independent living. Another southern State planned to create foster care opportunities for adults, placing them with members of the community in one-to-one arrangements. A northwestern State proposed a program to provide consultation to staff and case planning to guests at a new supported housing program. The program would provide an alternative to typical shelters. It would be open and staffed 24 hours per day, residents would not have to move out each morning, rooms would be single or double occupancy, and supervision would be offered onsite.

Consumer involvement. Very few States made any reference to consumer involvement in the delivery of the proposed services. Those States that did, proposed the use of consumer outreach workers or companions, encouragement of self-help groups, and consumer involvement in staff training. For example, a New England State proposed the use of peer outreach workers to engage homeless mentally ill persons in their own environments in order to build rapport that might not be feasible in more formal settings. A southern State planned to develop a crisis intervention team at each grant location. Each team would include a consumer service worker. A second consumer service worker would provide home-based services after working hours.

Drop-in centers and day programs. Several States proposed to use a portion of their funds to establish day treatment or drop-in centers. For example, an eastern State planned to develop multipurpose drop-in centers which would provide showers, laundry facilities, clothing, food, and a mailing address. Outreach, counseling, primary health care, substance abuse treatment, case management services, and training for service providers would be provided through the center. A southern State planned to establish low demand day shelters located downtown in four metropolitan areas. The shelters would provide bathrooms, lockers, laundry facilities, hot lunches, mental health counseling, medical assistance, and case management. Similarly, another southern State proposed the development of drop-in centers at each service site. The centers would offer food, bathing, and recreational facilities as a means of attracting potential consumers of mental health services.

Conclusion

Based on our review of State applications, it appears that the availability of funds under the MHSH program will enable many States to enhance existing services for homeless mentally ill persons, and it has given other States the incentive to begin developing services for this group. The diversity of approaches proposed to address the needs of homeless mentally ill persons is encouraging, given the extent of the unmet treatment and support needs among this population.

The States' proposals provide information about the intended use of MHSH Block Grant funds. States are required to submit annual reports which describe activities actually undertaken under the MHSH block grant program. The reports may permit a more refined analysis of what services are being provided, and who is being served by the program.

References

1. A report to the Secretary on the homeless and emergency shelters. Department of Housing and Urban Development, Washington, DC, 1984.
2. Hombs, M. E., and Snyder, M.: Homelessness in America: a forced march to nowhere. The Community for Creative Non-violence, Washington, DC, 1982.
3. Homeless mentally ill: problems and options in estimating numbers and trends. General Accounting Office, Washington, DC, 1988.
4. Tessler, R. C., and Dennis, D. L.: A synthesis of NIMH-funded research concerning persons who are homeless and mentally ill. National Institute of Mental Health, Rockville, MD, 1989.
5. Synopses of NIMH-funded Mental Health Services Demonstration Projects for the Homeless Mentally Ill. National Institute of Mental Health, Program for the Homeless Mentally Ill, Rockville, MD, 1988.