A National Agenda for Helping Homeless Mentally Ill People

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A tearsheet of this article or the publication, "Outcasts on Main Street: Report of the Federal Task Force on Homelessness and Severe Mental Illness," published in March 1992, may be obtained from the Office of Programs for the Homeless Mentally Ill, National Institute of Mental Health, Room 7C-08 Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857.

The Interagency Council on the Homeless is responsible for coordinating all Federal activities concerning the homeless population. Its Chairman is Jack Kemp, Secretary of Housing and Urban Development, and its Vice Chairman is Louis W. Sullivan, MD, Secretary of Health and Human Services and head of the Federal Department that includes the Public Health Service.

In May 1990, the Council convened a 12-member Task Force on Homelessness and Severe Mental Illness, consisting of representatives from all major Federal Departments and Agencies whose policies and programs directly affect the homeless severely mentally ill population. Its charge was to develop a national plan of action to end homelessness among mentally ill persons.

The members of the Task Force have been guided in their deliberations by a 16-member Advisory Committee appointed by Dr. Sullivan that includes experts in diverse fields ranging from mental health research to housing administration. Citizen advocates, mental health consumers, and family members are represented, as well as State and local officials concerned with severe mental illnesses and homelessness.

In addition, the Task Force has made extensive efforts to reach out to relevant non-Federal organizations and groups to solicit information and guidance. In mid-June 1991, a letter of inquiry was sent to nearly 20,000 individuals and organizations throughout the nation, soliciting advice and recommendations. The responses to this letter were carefully read and analyzed.

A series of workshops was convened with groups of experts on topics central to the Task Force charge—including housing, minority, consumer, rehabilitation, and legal issues.

Finally, Task Force members participated in a public hearing on severe mental illness and homelessness held September 5, 1991, in Chicago. The hearing, jointly sponsored by the National Advisory Mental Health Council and the National Mental Health Leadership Forum, resulted in relevant testimony from numerous individuals and organizations around the country.

In response to its charge from the Interagency Council on the Homeless, the Task Force, in its report, offers more than 50 action steps that Federal Departments will take to end homelessness among severely mentally ill people. These steps are intended to improve substantially this country's system of care and housing options for homeless mentally ill persons by making essential resources, both traditional and novel, more accessible to these disabled Americans.

Following are excerpts from the Task Force report, including major findings, recommendations, and action steps to end homelessness among people with severe mental illnesses.

There is no single, simple solution to the problems of homelessness among the severely mentally ill population across our nation. Any successful effort to end their homelessness must be a pluralistic one, involving Federal, State, and local governments as well as providers, mental health consumers, family members, and voluntary organizations. Each community must discover and develop the most effective configuration of resources to meet its needs.

To ease and hasten this process of discovery, the members of the Task Force on Homelessness and Severe Mental Illness have developed action steps to address four main goals: (*a*) promoting systems integration, (*b*) expanding housing options and alternative services, (*c*) improving outreach efforts and access to existing programs, and (*d*) generating and disseminating knowledge and information.

While solutions to this problem must be multifaceted, the emphasis on the Federal role reflects the special expertise as well as the belief that

appropriate Federal leadership can stimulate the changes required to end homelessness among severely mentally ill people in America. A sampling of the Federal action steps includes

Promote Systems Integration: the ACCESS Initiative

There is growing consensus that a system of care for people who are homeless and severely mentally ill requires integrating basic life supports, such as food, clothing, and shelter, with specialized services like treatment of mental illness, alcohol abuse, and drug abuse; linking services at the client and system levels; coordinating Federal, State, and local resources; and providing a clear delineation of authority and of clinical, fiscal, and administrative responsibility. For most communities in the United States, services integration is more an ideal than a reality. Thus, the Task Force sought to develop new incentives to help communities explore ways to make this integration happen.

The Department of Health and Human Services (HHS), in collaboration with the Department of Housing and Urban Development (HUD), the Department of Labor (DOL), the Department of Education (DOEd), the Department of Veterans Affairs (VA), and the Department of Agriculture (USDA), will make Access to Community Care and Effective Services and Supports (ACCESS) grants available to the States.

This innovative interdepartmental effort will test promising approaches to services integration within 20 to 30 communities selected to receive immediate assistance in ending homelessness among severely mentally ill people. The Federal Government will provide extensive pre- and post-award technical assistance to help each community take full advantage of available resources.

Other action steps to promote systems integration include

- HHS (National Institute of Mental Health, NIMH) and the Department of Justice will develop a Memorandum of Understanding to stimulate diversion to appropriate treatment settings those homeless people with severe mental illnesses who are inappropriately placed in jails.
- DOL, HHS, and DOEd will establish a Memorandum of Understanding to guide collaborative efforts to address knowledge gaps and stimulate policy and program development in meeting the rehabilitation and job training needs of the homeless mentally ill population.

Expand Housing Options and Alternative Services: Safe Havens

Despite widespread agreement that homeless people with severe mental illnesses need "safe havens" that place few demands on residents, constitute a place to stay during the day, offer the same bed each night, and provide storage for belongings, few now exist. To fill this void in the service system, HUD will propose to the Congress a new, competitive demonstration program of safe havens designed to determine the feasibility of providing low-cost stable housing for homeless mentally ill people living on the street.

This expanded housing option is intended to meet the needs of people who are initially reluctant to participate in structured programs. It offers a low-demand environment that provides safety, security, supervision, and support. It will be more stable than shelters because residents can use the same bed each night and are not forced to leave. These facilities will provide opportunities for residents to establish ties to treatment, benefits, and other support services.

Support would be provided for the rehabilitation and operating costs of safe havens. Grants would be awarded competitively and would include operating costs for a 5-year period, with the possibility of renewal in future years.

Additional steps to expand housing options and alternative services include

- HUD is seeking congressional approval for full funding in fiscal 1993 for its Shelter Plus Care (S+C) program that provides flexible rental assistance for a wide array of living arrangements including single-room-occupancy (SRO) units, group homes, and individual apartments; and
- HUD is recommending to the Congress amendment of the McKinney Act so that the existing three components of the S+C program would be folded into one offering three types of rental assistance—tenant-based, project-based, and sponsor-based—which will provide more flexibility and responsiveness to local needs and conditions.

Improve Outreach and Access to Existing Programs

A major finding of the Task Force has been the recognition that existing Federal programs and benefits relevant—and often essential—to homeless people with severe mental illnesses are not being fully used. Among the measures proposed to over-

Members of the Task Force on Homelessness and Severe Mental Illness

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Department of Justice
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Department of Labor
Raymond Uhalde, Administrator, Office of Strategic Planning and Policy Development, Employment and Training Administration.

Department of Education
Michael Vader, Deputy Assistant Secretary, Office of Special Education and Rehabilitative Services.

come these problems and ensure that Federal programs reach their intended target populations are these:

- HHS' Social Security Administration (SSA) will continue to increase outreach activities to homeless individuals, especially to homeless mentally ill persons, to demonstrate effective, efficient, ongoing, and transferable approaches for identifying potentially eligible individuals, assisting them through the application process, helping them to continue to receive SSI benefits as long as they remain eligible, and linking them with other available and appropriate financial benefits and social services. These efforts, including a special joint SSA-VA initiative, are directed at improving the quality of their lives and helping them obtain the greatest possible measure of independence.
- A basic component of the VA Homeless Chronically Mentally Ill (HCMI) Veterans Program is assertive outreach to homeless mentally ill veterans in shelters, at soup kitchens, and on the streets. The VA will expand outreach to local homelessness coalitions and nonprofit organizations at its HCMI and Domiciliary Care for Homeless Veterans Program sites.

Generate and Disseminate Knowledge and Information

Substantial resources, both public and private, are available to improve the lives of homeless people, including those who are severely mentally ill. However, many communities, service providers, and eligible individuals are not making use of them—especially those offered by the Federal Government—because they are unaware that such resources are available. The following action steps are designed to address critical information gaps and promote the coordination required to close them:

- HHS' Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) will undertake a national community education initiative to inform the public about the homeless population with co-occurring alcohol, drug, and mental health disorders. This initiative will include research and research demonstration programs as well as dissemination of information through publications and conferences.
- HHS' NIMH and Office for Treatment Improvement of ADAMHA will fund an integrated treatment center to assess the efficacy of this approach in treating homeless mentally ill persons with co-occurring alcohol or other drug disorders or both. Comprehensive psychosocial and psychiatric assessments, together with appropriate medical interventions, would be supported through a central intake, assessment, and referral unit. Housing, vocational rehabilitation, and other essential elements of an integrated system of care would be ensured.
- Building on Task Force priorities and earlier McKinney research demonstration efforts, and consistent with the NIMH National Plan of Research to Improve Services, NIMH will sponsor the development, evaluation, refinement, testing, and dissemination of exemplary models of integrated services for the homeless severely mentally ill population. Research on access to care, utilization, organization, costs, financing, and outcomes of service delivery systems will be promoted. The objectives of these efforts are to improve clinical

care and outcomes, increase efficiency and effectiveness, and inform mental health and health care policy.

Continuing Oversight: Role of the Interagency Council

A sustained effort is required to address the complex factors that cause and prolong homelessness among people with severe mental illnesses. Therefore, we have recommended, and the Interagency Council on the Homeless has agreed, that the Council will develop, within 60 days from the issuance of this report, a plan for monitoring and tracking the completion of each of the Federal action steps outlined in the report and for identifying new opportunities to assist States and localities in meeting the needs of their homeless mentally ill citizens.

Additionally, a committee of the Council, working closely with NIMH and other agencies, will be constituted to provide integrated Federal leadership and oversight to address the needs of homeless severely mentally ill people on an ongoing basis.

Impact of a Local Ordinance Banning Tobacco Sales to Minors

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Synopsis

Most addictions to tobacco begin when a person is younger than age 18. Although the sale of tobacco to minors is illegal in most jurisdictions, there is often little enforcement of these laws, and minors can usually purchase tobacco easily.

The impact of a local ordinance designed to prevent tobacco sales to minors was assessed by surveys of 10th grade students before and after the implementation of the ordinance.

Tobacco use declined from 25.3 percent to 19.7 percent overall, with a significant (P = 0.004) decline from 26.4 percent to 11.5 percent among girls. There was also a significant (P = 0.008) increase from 29.3 percent to 61.5 percent in the proportion of students reporting they were asked for proof of age when they attempted to purchase tobacco. Local ordinances may be an effective tool for reducing tobacco use by adolescents.

The age at which the use of tobacco begins is a critical variable in targeting prevention efforts. Unfortunately, tobacco use often begins during early adolescence and appears to be occurring at younger ages among more recent birth cohorts, especially among girls (*1*).

Although 43 States and the District of Columbia have laws prohibiting the purchase of tobacco by minors (*2*), it has been documented that such laws often have little or no effect and that purchase of tobacco by minors occurs often (*3,4*). In a recent survey by the Inspector General of the U.S. Department of Health and Human Services, two-thirds of State health department officials indicated that there is virtually no enforcement of their State law. What enforcement exists is typically of local ordinances (*5*). Everett, WA, is one city that has implemented a local ordinance designed to reduce access to tobacco by adolescents under age 18. Surveys of 10th grade students in a local high school suggest that the ordinance may be having a positive effect.

Methods

In November 1988, the Snohomish Health District Board recommended to all cities within the district that a model ordinance be adopted with the objective of reducing access of minors to tobacco. The city of Everett (population 66,740) adopted the ordinance in the spring of 1989, with an implementation date of January 1, 1990. The delay in implementation provided an opportunity for a survey to be conducted in the local high school.

In October 1989, and again in October 1990, a one-page questionnaire was distributed to 10th grade students at the high school. This grade level was used because anecdotal information suggested