State of the States: Services for Persons Who Are Homeless and Mentally Ill

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The problem of homelessness among persons who are mentally ill and homeless or at risk of homelessness requires the development of partnerships and collaborative efforts among agencies, organizations and individuals across both public and private spectrums. The National Association of State Mental Health Program Directors (NASMHPD) and its National Technical Assistance Center for State Mental Health Planning (NTAC) have been fortunate in being able to call upon the support and guidance of a number of critical individuals and organizations in completing this project. Our gratitude goes to the author of this report, Bruce D. Emery, M.S.W., for his leadership and guidance in gathering, organizing, assessing and presenting the data and other information that serve as the basis for this report.

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We also wish to acknowledge the contributions of advocates for persons with mental illness who are homeless or at risk of homelessness, especially Robert Reeg of the National Coalition for the Homeless. The areas in which NASMHPD and NTAC focused their efforts and attention in the course of this project were significantly influenced by the recommendations of the coalition.

The task facing those individuals and agencies committed to providing effective services to persons with mental illness who are homeless or at risk of homelessness is complex, yet there are many who have taken

up the challenge and who are making significant inroads into the problem. We admire their efforts and hope that this report contributes in some measure to their ongoing work.

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Executive Summary

Introduction

The National Association of State Mental Health Program Directors (NASMHPD) has a long-standing interest in the provision of housing and other services and supports for persons with mental illness. In 1987 NASMHPD issued a "Position Statement on Housing and Supports for People with Psychiatric Disabilities," revised in 1996, that helped establish a foundation on which states could build their housing-related efforts. That same year NASMHPD also established a President's Task Force on Housing and Supports for Persons with Psychiatric Disabilities that has guided the association's numerous housing initiatives—conducted in partnership with the federal Center for Mental Health Services (CMHS), other national organizations and the states themselves—that include a range of meetings, workshops, training institutes and publications.

The purpose of this report is to explore the availability of state mental health system programs for persons who are mentally ill and homeless (or at risk of homelessness) that are not funded through the federal Program for Assistance in Transition from Homelessness (PATH). Path is a formula matching-grant program funded by the Center for Mental Health Services. Because PATH program services already are well documented and evaluated, the goal of this project has been to more fully discern the nature and extent of services developed by states for mentally ill persons who are homeless or at risk of homelessness funded through other, non-PATH sources.

Methodology

Data on the non-PATH housing services addressed in this report are derived from several sources. The primary source has been direct, ongoing communication with state mental health agency staff regarding specific data elements and other information. Two additional data sources have been used:

- state mental health block grant plans
- the State Mental Health Agency Profiles System data base, which is funded by the Center for Mental Health Services and developed and maintained by the NASMHPD Research Institute, Inc. (NRI)

Taken together these three sources represent the most reliable and comprehensive data regarding non-

PATH services provided through state mental health agencies for persons who are homeless and mentally ill. It should also be noted that a separate study of services for persons who are homeless and diagnosed with substance abuse is currently being conducted by the National Association of State Alcohol and Drug Abuse Directors.

Findings

Data were obtained from 45 of the 55 U.S. states and territories and, unless otherwise specified, apply to fiscal year 2001. The following are among the report's key findings:

- The majority of the 45 responding states and territories (28 or 62%) identify persons who are mentally ill and homeless or at risk of homelessness as a high-priority population. The length of time that this population has been designated as a special priority ranges from the very recent (i.e., within the past two years) to a decade or longer.

- Approximately 600,000 individuals are homeless throughout the country on any given night. Of these individuals, about one-third have serious mental illnesses.

- A majority of states (32 or 71%) for whom data were available require that community-based service providers who receive funds from the state mental health agency collect information on the housing status of persons receiving mental health services.

- The percentage of persons receiving mental health services who are homeless varies among states from less than 1 percent to 19 percent. Most states report that this population comprises less than 5 percent of their total community-based program caseloads.

- Twenty-four states (53%) indicate that they use a portion of their state mental health block grant allocation to fund housing services and supports.

- Of the states included in this analysis, 19 (42%) gather information on non-PATH services provided to persons who are homeless and mentally ill.

- States identified a variety of federally funded programs that have been instrumental in establishing a base of services for this population, including public housing programs, Section 8 subsidies, Section 811 ("Supportive Housing for Persons with Disabilities") and the ACCESS demonstration program.

- State mental health agencies use state funds for housing supports and services to leverage a wide

range of housing resources and often mandate interagency collaboration in the development of supportive housing projects.

- A number of states have developed creative program and fiscal incentives to influence the development of programs for persons who are mentally ill and homeless or at risk of homelessness.

- Virtually all of the states participating in this analysis expressed a commitment to discharge individuals from state psychiatric hospitals only upon availability of appropriate community residential placement.

- More than one-third of states (16 or 35%) have representatives on state mental health planning and advisory councils who are currently or were formerly mentally ill and homeless.

Observations and Recommendations

NTAC project staff have maintained ongoing contact with state staff whose responsibilities include the development, financing, documentation and evaluation of services for persons who are mentally ill and homeless or at risk of homelessness. The perspectives provided by individuals with broad expertise and experience in this field, together with the data and information presented in this report, make it possible to advance a number of observations and recommendations. Recommendations noted below reflect the primary concerns of state mental health agency staff with whom project staff consulted during the process of gathering and assessing data for this report.

Observations

- The PATH program, as well as other federally initiated efforts such as the Mental Health Block Grant, has provided valuable and at times essential guidance and support to states in addressing the problems of homelessness among persons with mental illness.

- Variability among state information systems makes state-by-state comparisons of need, services and financing somewhat problematic. The report should be read with this observation in mind.

- States have learned a great deal about effective interventions with homeless persons from their own experience and that of other states, as well as from technical assistance organizations and federal agencies.

- State commitments to fund services for persons who are mentally ill and homeless have often continued after the expiration of categorical federal funding, based on the belief that these programs

are too valuable to terminate.

- Larger metropolitan areas such as Boston, Denver, New York City and St. Louis usually have the most extensive support services for person with mental illness who are homeless.

Recommendations

The following are among the report's key recommendations:

- *Increase access to affordable housing:* More—and more affordable—housing opportunities need to be made available to persons disabled by mental illness.

- *Strengthen key partnerships*: Strong partnerships at the state and federal levels can lead to more effective resource sharing and service delivery at the local level.
- *Share best practices:* The Substance Abuse and Mental Health Services Administration (SAMHSA) and its component centers should continue their support of and expand current state and federal efforts to provide technical assistance in disseminating best and promising practices to the field.

- *Improve data and program planning:* Technical assistance should be made available to state mental health agencies to help them accurately and consistently estimate the number of individuals who are mentally ill and homeless or at risk of homelessness in their states.

Introduction

The National Association of State Mental Health Directors (NASMHPD) has a long-standing interest in the provision of housing and related services for persons with mental illness. In 1987 NASMHPD issued a "Position Statement on Housing and Supports for People with Psychiatric Disabilities" that represented a significant step forward in helping to establish a national policy direction in housing for persons with psychiatric disabilities. Revised in 1996, the position statement helped to establish a foundation on which states could build their housing-related efforts.

In 1987, NASMHPD established a President's Task Force on Housing and Supports for Persons with Psychiatric Disabilities that has guided the association's numerous housing activities from planning through implementation to evaluation. These activities—most often in partnership with the Center for Mental Health Services, other national organizations and the states themselves—have included convening of a National Focus Group on Housing in March 1995; implementation of a "State of the States Housing Survey" in July 1995; convening of a National Experts Workshop in January 1996; publication of *Housing for Persons with Psychiatric Disabilities: Best Practices for a Changing Environment* in November 1996 and a special issue of the newsletter of NASMHPD's National Technical Assistance Center for State Mental Health Planning in fall1996; and convening of a National Senior Executive Training Institute on Housing in September 1997.

Programs for Assistance in Transition from Homelessness (PATH) is a formula grant program funded by the federal Center for Mental Health Services (CMHS). PATH funds and the required state match provide a broad range of mental health services for people who are mentally ill and homeless or at risk of homelessness. With a federal funding increase of 6 percent from FY 2000 to FY 20001, the PATH program has encouraged states to develop and expand their services for persons who are mentally ill and homeless or at risk of homelessness.

Although PATH funds support the greatest portion of the efforts in many states to develop housing for persons with psychiatric disabilities who are homeless or at risk of homelessness, states also deliver non-PATH funded services. It is those non-PATH services on which this project focuses since services offered through the PATH program are well documented and evaluated as a requirement of the funding mechanism.

PATH and non-PATH service efforts may be closely related in that they address the needs of persons who are homeless or at risk of homelessness. They may be administered by the same state and local staff and may, in fact, offer quite similar services. The objective of this project has been to more fully discern the nature and extent of services developed by states for mentally ill persons who are homeless or at risk of homelessness funded through other, non-PATH funding mechanisms.

As such, the information and data gathered and presented in this report are largely dependent upon states' ability to generate data reflecting what are essentially "non categorical" services for persons who are

homeless or at risk of homelessness. Since no specific funding source provides resources for a state level administrative support structure and no federal regulations explicitly guide states in developing services (except for general mental health block grant guidance to address "outreach and homelessness"), states' efforts to develop, fund and document non-PATH services for persons who are mentally ill and homeless or at risk of homelessness vary widely. This report reflects and summarizes as far as possible those individual state-level choices.

Methodology

Data Sources

Data included in this project are derived from several sources. The primary source of data regarding non-PATH services for persons who are homeless and mentally ill has been direct communication with state mental health agencies. As the study has progressed, NASMHPD staff have maintained written, electronic and verbal communication with state mental health agency staff regarding the specific data elements listed below. These discussions—extending from approximately September 2000 through the present—have provided ongoing clarification and expansion of available information.

Two additional essential data sources have been incorporated into the study to supplement knowledge of the status of non-PATH service delivery to persons who are homeless and mentally ill: state mental health block grant plans and the State Mental Health Agency Profiles System data base funded by the Center for Mental Health Services and developed and maintained by the NASMHPD Research Institute, Inc. (NRI). These two sources provide additional perspectives on mental health services for homeless persons.

The mental health block grant data used for the report was derived from an analysis of state block grant expenditures conducted by NASMHPD beginning in March 2000. States provided information regarding a series of key issues, including:

- services provided through mental health block grant funding, including housing-related support services;
- populations identified as priorities for service with current funding;
- populations identified as priorities for service with new funding; and
- average level of funding, by service.

Reviews of mental health block grant state plan applications resulted in a series of state-specific summary profiles which then supplemented this report. The database of the NRI State Mental Health Agency Profile System has long served as a significant resource in understanding the full range of services delivered and financed through each of the nation's state mental health agencies.

Taken together, these multiple data sources represent the most reliable and comprehensive source of data regarding non-PATH services provided through state mental health agencies for persons who are homeless and mentally ill.

This study analyzes data and information available through state mental health agencies. It should also be noted that information on state-specific services for persons who are homeless and diagnosed with substance abuse was designated for a separate study to be conducted through the National Association of State Alcohol and Drug Abuse Directors (NASADAD). The close working relationship that exists between NASMHPD and NASADAD has promoted ongoing discussions between the staff of the two associations as both studies have proceeded.

Data Elements

A project of this nature inevitably challenges participants to reach for data and information that is desirable but may not, in fact, be obtainable given existing constraints of time and resources. Consequently, in developing the data elements for analysis, project planners reviewed the currently available data sources noted above and agreed to assess the following information as representing many of the most important elements to inform ongoing discussions of homelessness and mental illness:

- states that designate persons who are homeless and mentally ill as a priority population,
- information available on persons in the state's general population who are homeless and mentally ill,
- means of collecting incidence/prevalence data,
- non-PATH mental health services available for persons who are homeless and mentally ill,
- non-PATH mental health services delivered to persons who are homeless and mentally ill,
- duplicated or unduplicated count of persons receiving services,
- state policy regarding collection of data by community providers on the housing status of persons receiving mental health services,
- percentage of persons receiving mental health services who are also homeless,
- strategies used by states to encourage the development of targeted mental health services for persons who are homeless and mentally ill,
- state hospital discharge policies,
- mechanisms used to evaluate effectiveness of services,
- states in which a homeless/formerly homeless person is a member of the Mental Health Planning and Advisory Council,
- primary sources of non-PATH funding for services to persons who are homeless and mentally ill, and
- annual expenditures of non-PATH funds for homelessness-related services.

Findings

This report is based upon data from 45 of the 55 U.S. states and territories from which information was requested for this study. Data were unavailable from 10 of the states and territories. The extent of the data which is available to review as part of this analysis and the accuracy of that information—as assessed by the states themselves—varies as a function of the states' activities in developing housing for persons with mental illness who are homeless or at risk of homelessness.

In some states, state mental health agency efforts to develop services that respond to the needs of persons with mental illness who are homeless or at risk of homelessness are longstanding and sophisticated. States such as Connecticut, Maryland, Massachusetts, Ohio, Oregon and Texas have been grappling with the need for stable, affordable and integrated housing for many years. In other states, the unique and state-specific nature and extent of the problem of providing housing for persons with serious mental illness has become more clear in recent years, leading to state-level efforts to respond to what is now generally recognized as a national challenge. The findings presented and assessed below are based upon data and information available from individual states and territories. Unless otherwise specified, data apply to fiscal year 2001.

State and Territory Designation of Persons Who Are Homeless and Mentally Ill as a Priority Population

Table 1 addresses the question of whether states and territories designate persons who are mentally ill and homeless or at risk of homelessness as a special priority population. The table demonstrates that the majority of the 45 states and territories (28 or 62%) for whom information is available identify this population as a special priority.

Table 1: States and Territories that Designate Population as a Special Priority

AL	*N*	CT	*Y*	ID	*N*	ME	*Y*	MT	*N*	NC	*ni*	RI	*Y*	VI	*N*
AK	*ni*	DC	*ni*	IL	*N*	MD	*Y*	NE	*N*	ND	*N*	SC	*Y*	VA	*Y*
AS	*ni*	DE	*Y*	IN	*N*	MA	*Y*	NV	*N*	OH	*Y*	SD	*ni*	WA	*Y*
AZ	*N*	FL	*N*	IA	*N*	MI	*ni*	NH	*Y*	OK	*Y*	TN	*N*	WV	*ni*
AR	*N*	GA	*Y*	KS	*Y*	MN	*Y*	NJ	*Y*	OR	*N*	TX	*N*	WI	*N*
CA	*Y*	GU	*Y*	KY	*Y*	MS	*ni*	NM	*Y*	PA	*Y*	UT	*Y*	WY	*Y*
CO	*Y*	HI	*Y*	LA	*Y*	MO	*Y*	NY	*Y*	PR	*ni*	VT	*ni*		

y - yes; n - no; ni - No information was provided by state.

States vary widely in terms of the mechanisms they use to designate this group as a special priority for service. They may choose more than one mechanism to identify the population. Among those states which noted a specific mechanism, three were most frequently mentioned:

1. *Legislation*	California, Connecticut, Maine, Minnesota, New York, Utah and Virginia
2. *Court or Executive Order*	California, Colorado, Guam, Maine, Maryland, New Mexico and New York
3. *Planning and Funding Priorities*	Georgia, Hawaii, Louisiana, Massachusetts, New Jersey, Ohio, Pennsylvania, Rhode Island, South Carolina and Washington

The length of time that the population of persons who are mentally ill and homeless or at risk of homelessness has been designated as a special priority ranges from the very recent (i.e., within the past two years) in Georgia, Utah, Virginia and Washington to a decade or longer in California, Connecticut, Hawaii, Kansas, Maryland, New Jersey, New York, Ohio and South Carolina.

Data on Persons Who Are Homeless and Mentally Ill in States' General Population

The problem of homelessness in this country presents a daunting challenge to those who advocate for and respond to their needs. According to a recent collaborative study by the federal Center for Mental Health Services (CMHS) and the federal Center for Substance Abuse Treatment (CSAT), approximately 600,000 individuals are homeless throughout the country on any given night.[1] Of these individuals, approximately one-third have serious mental illnesses.[2]

State-by-state estimates of the extent of homelessness and mental illness are reached through different estimation methods and are not comparable across the country. Of the 45 states that contributed to the information base for this project, 22 (49%) collect some information on persons who are homeless and

[1]Center for Mental Health Services and Center for Substance Abuse Treatment. (2000). *Insights and Inroads: project Highlights of the CMHS and S\CSAT Collaborative Demonstration Program for Homeless Individuals.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

[2]Tessler, R., and Dennis, D.L. (1992). "Mental Illness Among Homeless Adults: A Synthesis of NIMH-Funded Research." In J. Greeley and P. Leaf (eds.), *Research in Community and Mental Health.* Vol. 6, Greenwich, CT: JAI Press.

mentally ill. Of those 22 states, needs estimates are available for 18 states.

Estimates of need, the time period for their collection and methods of estimation vary widely, as Table 2 indicates. The reliability of the data cannot be assessed at this time. A number of states indicate that they would welcome assistance in developing more timely and statistically reliable data

on the number of persons in their general population who are mentally ill and homeless or at risk of homelessness.

Table 2: Estimates of Persons with Mental Illness Who Are Homeless in the General Population

State	Estimate	Date	Collection Method	State	Estimate	Date	Collection Method
AL	2,349/year	2000	provider sample	KS	na		
AZ	na			KY	na		
AR	na			LA	na		
CA	50,000	2000	census data, legislative and county report	ME	807/year	na	service providers
CO	na		Denver metro area	MD	na		
CT	3,000-5,000	PIT*	advocacy data/ Dept. of Social Services	MA	na		
DE	200-260	1995	Univ. Delaware study	MN	na		survey in progress
FL	2,100/year	2000	state data system	MO	65,000/year	na	adj. census data
GA	6,875/night	1998	1998 Action Plan	MT	na		
GU	na			NE	99/night	na	homeless shelters
HI	2,100/year	1999	Community Health	NV	42,228/year	1999	
ID	na		providers/shelters	NH	865/year	1988	homeless shelter
IL	na			NJ	11,000/year	1999	census and poverty estimates
IN	20,000/year	na		NM	na		
IA	na			NY	na		

* point in time
na: Specific information not available from responding state.

Table 2: Estimates of Persons with Mental Illness
Who Are Homeless in the General Population *continued*

State	Estimate	Date	Collection Method	State	Estimate	Date	Collection Method
ND	na			TX	na		state formula
OH	23,420/year	2000	Coalition for Homelessness/ Housing of Ohio	UT	1,200/night	1999	PATH reports, consolidated plans and shelter
OK	na			VI	na		
OR	6,000- 8,000/year	1988	twice yearly shelter count	VA	na		
PA	na			WA	na		
RI	105/night	1993	street level/shelter bed study	WI	na		
SC	na			WY	na		
TN	na						

* point in time
na: Specific information not available from responding state.

Persons Receiving Mental Health Services Who Are Homeless and Mentally Ill

A majority of the states (32 or 71%) for whom data are available require community service providers funded through the state mental health agency to collect information on the housing status of persons receiving mental health services. Housing status information may be collected at several different points of contact with the individual: at admission, at various stages in treatment and at discharge. Most states collect housing status information at the point of client admission.

The percentage of persons receiving mental health services who are also homeless varies among these states from less than 1 percent in Rhode Island to 19 percent in Maryland (Table 3). Estimates for some states which indicate that they do, in fact, collect information regarding the housing status of persons receiving mental health services are unavailable at this time. In some cases, states and territories that do not require community providers to collect information on the housing status of persons receiving mental health

services have, nonetheless, provided estimates of the number of persons on community provider caseloads who are also homeless (Guam, Maryland, New Jersey, New York). In most cases, the percentage of persons receiving mental health services who are homeless is estimated at less than 5 percent of the total community-based program caseload.

Table 3: States Requiring Collection of Housing Status Information and Percentage of Persons Receiving Mental Health Services Who Are Homeless

State	Community Providers Collect Info. on Housing Status	Percentage Served Who Are Homeless		State	Community Providers Collect Info. on Housing Status	Percentage Served Who Are Homeless
Alabama	Yes	5%		Montana	No	
Arizona	Yes	4.3%		Nebraska	Yes	na
Arkansas	Yes	2.1%		Nevada	No	
California	Yes	na		New Hamp.	Yes	na
Colorado	Yes	2.6%		New Jersey	No	3%
Connecticut	Yes	1.5%		New Mexico	No	
Delaware	Yes	9.5%		New York	No	4.8%
Florida	No	2%		N. Dakota	Yes	16%
Georgia	No			Ohio	Yes	3.63%
Guam	No	10%		Oklahoma	Yes	5%
Hawaii	Yes	15%		Oregon	Yes	5-7%
Idaho	Yes	4%		Pennsylvania	Yes	na
Illinois	Yes	3.1%		Rhode Island	Yes	<1%
Indiana	Yes	5%		S. Carolina	Yes	5%
Iowa	No			Tennessee	No	
Kansas	Yes	1.6%		Texas	No	
Kentucky	Yes	3.3%		Utah	Yes	2.5%
Louisiana	Yes	na		Virgin Islands	No	

Maine	Yes	4%				
Maryland	No	19%		Virginia	Yes	2%
Massachusetts	Yes	8%		Washington	Yes	4 %
Minnesota	No			Wisconsin	Yes	<3%
Missouri	Yes	2%		Wyoming	Yes	2%

na: Specific information not available from responding state.

Non-PATH Mental Health Services Delivery and Development

A key question motivating this study is related to non-PATH services that states offer to persons who are homeless and mentally ill. Of the states included for analysis, 19 (42%) gather information on non-PATH services provided to persons who are homeless and mentally ill, including inpatient, outpatient, outreach, supported housing, housing location assistance, security deposits, case management, rental subsidies and jail diversion. Table 4 reflects the number of persons receiving non-PATH services in these states. Whenever possible, figures are unduplicated counts of persons receiving services in all service areas.

Table 4. Non-PATH Services Provided to Persons Who Are Homeless and Mentally Ill

Services Provided and Number of Persons Served Per Year									
State	**In-patient**	**Out-pat.**	**Outreach**	**Supp. Housing**	**Housing Loc. Assist.**	**Security Deposits**	**Case Mgt.**	**Rent Sub.**	**Jail Div.**
Arkansas	53	1,457		1,397					
Colorado				905					
Connecticut	128	333	393	135	233	108			
Hawaii			814	35					
Idaho		158							
Illinois	1,163	4,793							
Indiana	217	556							
Iowa				50		50		50	
Kansas		1,815			94		94		
Kentucky	327	396							
Maryland					3,874	453			2,160

Mass.		840	1,000	1,916	700		610	1,100	
Minnesota								36	
New York	574	2,572	1,049	1,118					
Ohio	534	1,710		880					
Oregon		1,362	980						
S. Carolina		2,596		981					
Wisconsin	189	182		37					

Development of Targeted Mental Health Services for Persons Who Are Homeless and Mentally Ill

States have relied upon federally funded programs for persons who are mentally ill and homeless or at risk of homelessness in their efforts not only to initiate services for this group of individuals but also to develop and maintain the administrative infrastructure necessary to support those services. This infrastructure provides the backbone of administrative support for a host of housing-related services over time.

In sharing the mechanisms used to encourage development of targeted mental health services for persons who are mentally ill and homeless or at risk of homelessness, states frequently mentioned the following federally-funded programs in addition to PATH as instrumental in establishing a foundation of services for this population: public housing programs, Section 8 subsidies, Emergency Shelter Grants, Shelter Plus Care, Supportive Housing Programs (including Safe Havens), Section 811 ("Supportive Housing for Persons with Disabilities") and the ACCESS demonstration program. A number of states have, in fact, continued to fund programs beyond their federal funding cycle because of their value to the population in need.

States have used creative programmatic and fiscal incentives (in addition to federal funding) to develop mental health services for persons who are homeless and mentally ill. In Arizona, Arkansas, Colorado, Hawaii, Massachusetts, Minnesota, Missouri and New Hampshire, contracts entered into with community-based providers include providing outreach services to meet the needs of persons who are mentally ill and homeless. Connecticut, Maine, New Jersey, New York and South Carolina have funded pilot programs and initiatives specifically designed to provide services and supports to persons who are mentally ill and homeless or at risk of homelessness.

Massachusetts uses state funding for housing supports and services to leverage a range of housing resources. The state's Medicaid managed mental health care contractor also targets services for persons who are homeless, as required by contract. Through the Supportive Housing Initiative Act of 1998, California has mandated interagency collaboration for the development of supportive housing projects for very low income individuals with disabilities. Persons with mental illness and substance abuse who are also homeless are part of the defined population for this program.

Delaware, Illinois, Rhode Island, Virginia and Wisconsin explicitly require that community treatment teams target the needs of homeless persons with mental illness. Ohio offers special incentives to county mental health authorities that use the recommended format and continuum-of-care data for planning and developing housing services. Washington requires that its regional service boards plan services for persons who are mentally ill and homeless as part of the state's pre-paid health plan network.

Financing of Services

The Mental Health Block Grant program has served as an important source of both funding and guidance for state service initiatives for persons with mental illness who are homeless. Colorado, Georgia, Guam, Iowa, Kentucky, Nevada and Pennsylvania, among others, note that mental health block grant and its planning process have served as important mechanisms to leverage development of services for persons who are mentally ill and homeless. The value of the mental health block grant in helping to develop services for persons who are mentally ill and homeless or at risk of homelessness across the nation is clear. Table 5 lists FY 2001 Mental Health Block Grant allocations by state and territory, **including four territories (Marshall Islands, Micronesia, Northern Mariana Islands and Palau) that were not requested to provide information for this study**.

Table 5: FY 2001 Allocation of Community Mental Health Services Block Grant by State/Territory

Alabama	$6,220,723	Kentucky	5,678.236
Alaska	762,905	Louisiana	6,102,402
American Samoa	69,438	Maine	1,762,274
Arizona	6,657,364	Marshall Islands	66,413
Arkansas	3,607,391	Maryland	8,384,454
California	54,652,725	Massachusetts	8,443,383
Colorado	5,094,169	Michigan	13,278,250
Connecticut	4,573,611	Micronesia	157,222
Delaware	943,578	Minnesota	5,828,519
DC	830,293	Mississippi	3,864,148
Florida	24,194,151	Missouri	6,887,730
Georgia	11,915,992	Montana	1,213,588

Guam	197,675	Nebraska	2,011,272
Hawaii	1,682,488	Nevada	2,756,629
Idaho	1,682,538	New Hampshire	1,448,762
Illinois	16,246,971	New Jersey	12,112,785
Indiana	8,220,321	New Mexico	2,181,353
Iowa	3,587,827	New York	28,257,608
Kansas	3,273,481	North Carolina	9,950,039

Table 5: FY 2001 Allocation of Community Mental Health Services Block Grant by State/Territory *continued*

North Dakota	$ 853,844	Tennessee	$ 7,945,336
Northern Mariana Islands	64,349	Texas	29,347,859
Ohio	15,027,530	Utah	2,667,382
Oklahoma	4,596,551	Vermont	816,103
Oregon	4,272,535	Virginia	10,661,315
Palau	50,000	Virgin Islands	151,144
Pennsylvania	16,433,134	Washington	8,527,239
Puerto Rico	5,228,758	West Virginia	2,630,833
Rhode Island	1,456,182	Wisconsin	6,683,935
South Carolina	5,411,135	Wyoming	474,141
South Dakota	899,986		
Source: Fiscal Year 2001 Center for Mental Health Services Block Grant Funding Report, August 30, 2001.			

States use a variety of other non-PATH funds administered through the State Mental Health Agency to support their efforts in developing and delivering services for persons who are mentally ill and homeless or at risk of homelessness. Of the 45 states and territories that provided information for this project, 25 submitted information on non-PATH expenditures for services to this population (Table 6).[3]

[3]This list is illustrative and not exhaustive. Specific funding figures by source of funds are not available for all states.

Table 6. Annual Non-PATH Services Expenditures for Persons Who Are Mentally Ill and Homeless/At Risk of Homelessness by Funding Source (in dollars)

State	Mental Health Block Grant	State Housing Finance Agency	Dept. Community Dev.	SMHA	General Rev.	Local Housing Dev. Agency
Arizona		8,000,000				
Colorado	120,000					
Connecticut	130,405			3,170,286		
Delaware					470,221	
Hawaii	76,367	162,900		260,433		63,239
Idaho					48,000	
Illinois					1,832,165	
Indiana	48,000					
Iowa				121,220		
Kansas					149,289	
Kentucky	88,400			118,347		
Maine		1,900,000		1,500,000		
Maryland	551,950		5,251,000	5,500,000	1,300,000	
Massachusetts	29,698	200,000	1,000,000	22,000,000		10,000,000
Minnesota		462,920		250,000		
New Jersey					1,582,388	

Ohio	770,002	5,230,000	516,921	4,500,000	6,000,000	8,193,042
Oklahoma	90,250			439,000	116,660	
Pennsylvania				5,453,593		
Rhode Island		1,108,426				
S. Carolina				200,000		
Tennessee					240,000	
Texas					187,500	
Virginia	700,000		632,736			
Wisconsin	10-15,000					

State Hospital Discharge Policies

The linkage between state psychiatric hospitals and the community plays an important role in maintaining the nation's behavioral healthcare system "safety net." One of the chief mechanisms through which the relationship between hospital and community can be understood is by reviewing discharge policies and procedures. Virtually all of the states participating in this analysis expressed a commitment to discharge individuals from the state psychiatric hospitals only upon availability of appropriate community residential placement, which is identified as part of the pre-discharge planning process. That commitment takes different forms and is articulated in a variety of ways.

The discharge policies of states such as Arkansas, Connecticut, Illinois, Maryland, Rhode Island, Tennessee, Virginia and Wisconsin indicate that individuals are not discharged from state psychiatric hospitals to the street or to homeless shelters. In other states, discharge to homeless shelters may occur in practice, but is generally discouraged. States such as Delaware, Iowa, Massachusetts and Nevada engage in ongoing efforts to link discharged clients to appropriate services in the community. In California, policies are county-specific and vary across the state.

Ultimately, the majority of states fall into the same category as Alabama, Colorado, Florida, Hawaii, Idaho, Maine, Minnesota, New York, Pennsylvania, South Carolina, Texas, Utah and Washington, which make every effort to locate appropriate community placement when a client is ready to leave
the hospital. In a small number of states, no official discharge policy exists regarding community placement (e.g., Arizona, Indiana, Kentucky, Missouri and New Hampshire).

Some states specifically note that they make aggressive attempts through community treatment teams to ensure that the linkage between individual and community services is made as planned. These states include Colorado, Connecticut, Delaware, New Jersey, Oregon, Pennsylvania and Rhode Island. The issue of discharge policies and practices should be viewed in its proper context. That is, persons hospitalized for civil commitment proceedings may be discharged abruptly after it is determined in a hearing that they are

not (or are no longer) "dangerous to self or others." These individuals may be more likely to be homeless than those who complete a course of treatment in a psychiatric hospital.

Program Evaluation

States evaluate services for persons with serious mental illness in a number of ways, including site visits, outcome assessments and consumer satisfaction surveys. While most often utilized as part of a broad evaluation strategy of services for persons with mental illness, these evaluation approaches may also be applied specifically to services for persons who are mentally ill and homeless. Although an examination of specific evaluation content was not undertaken as a component of this study, Table 7 displays the variety of evaluation mechanisms identified by 31 states to assess the effectiveness of their overall public mental health services.

Table 7. Evaluation Mechanisms Utilized

State	Site Visits	Outcome Assess.	Consumer Satisfaction Surveys		State	Site Visits	Outcome Assess.	Consumer Satisfaction Surveys
AL	x				MO		x	
AZ		x	x		NE			x
AR		x	x		NH		x	x
CA		x	x		NJ		x	
CT		x			NM		x	x
DE		x	x		OH		x	x
GA		x	x		OK		x	
HI		x	x		OR	x	x	x
ID			x		PA		x	
IL			x		RI		x	x
IN		x	x		SC		x	x
KS			x		TX			x
KY			x		UT	x		x
ME		x	x		WA	x		

MD		x	x		WY		x	x
MA	x	x	x					

Organizational Support

A previous study conducted by NASMHPD indicated that 42 states have *part-time or full-time lead housing* persons at the state mental health office.[4] Of those, 17 states employed lead housing persons who work full time on housing. An additional 25 states identified lead housing persons to focus part-time on housing, spending an average of just over one-third of their time on housing related issues. States with housing staff are more likely to have developed working interagency relationships with

housing and advocacy organizations and to have a targeted housing policy/strategy addressing issues of homelessness.

More than one-third (36%) of the states (n=16) have *representatives on the State Mental Health Planning and Advisory Councils* who are (or were formerly) mentally ill and homeless. These states are Arkansas, California, Hawaii, Idaho, Kansas, Kentucky, Louisiana, Maryland, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, South Carolina, Texas and Wyoming. Other states indicate that the specific interests of persons who are mentally ill and homeless are represented by homeless service providers or family members of persons who are homeless and mentally ill.

[4] National Technical Assistance Center for State Mental Health Planning. (1996). "State of the States Housing Survey (Appendix C)." In Hutchings, G.P., Emery, B.D., and Aronson, L.P. (Eds.), *Housing for Persons with Psychiatric Disabilities: Best Practices for a Changing Environment* (Technical Assistance Tool Kit). Alexandria, VA: National Association of State Mental Health Program Directors.

Observations and Recommendations

As this report was developed, data were analyzed and clarified on a state-by-state basis. Ongoing contact occurred with state staff whose responsibilities include the development, financing, documentation and evaluation of services for persons who are mentally ill and homeless or at risk of homelessness. The perspectives of individuals with broad expertise and experience, together with the data and information presented in this report, allow for a number of general observations and recommendations. Recommendations reflect the primary concerns and suggestions of state mental health agency staff with whom project staff consulted during the process of gathering and assessing data for this report.

Observations

- The PATH program, as well as other federally initiated efforts such as the Mental Health Block Grant, has provided valuableand at times essential guidance and support to states as they address homelessness within their jurisdictions.

- Variability among state information systems makes state-by-state comparisons of need, services and financing somewhat problematic. It can be difficult for states to identify their level of effort specific to homeless services. Distinguishing between PATH and non-PATH related services presents a significant challenge to existing information systems. The report should be read with this observation in mind.

- States have learned a great deal about effective interventions withhomeless persons from their own experiences and those of other states, as well as from technical assistance organizations (e.g., National Center on Homelessness and Mental Illness) and federal agencies.

- State commitments to fund services for persons who are mentally ill and homeless or at risk of homelessness have often continued after the expiration of categorical federal funding based on the belief that these programs were too valuable to terminate—such as occurred with the ACCESS demonstration program. Wherever possible, this report reflects these services.

- Larger metropolitan areas such as Boston, Denver, New York City and St. Louis usually have the most extensive support services for person with mental illness who are homeless. Much information is currently available from these and other sites regarding their experiences and the lessons that might guide other state efforts in serving this population.

Recommendations

- *Increase access to affordable housing*: More, and more affordable, housing opportunities need to be made available to persons disabled by mental illness. Poverty, the lack of affordable

housing and the stigma of mental illness all contribute to homelessness among persons with mental illness.

- *Strengthen key partnerships*: Strong partnerships at the state and federal levels can lead to more effective resource sharing and service delivery at the local level. State and federal authorities should continue their efforts to strengthen partnerships among agencies responsible for serving persons who are mentally ill and homeless or at risk of homelessness. Collaboration among the U.S. Departments of Housing and Urban Development, Health and Human Services, Labor, Justice and Education and the Social Security and the Veterans Administrations can produce a stronger, more responsive and effective system to meet the complex and unique needs of this population.

- *Share best practices*: States and communities benefit from sharing experiences in developing effective strategies for organizing and funding services and supports (e.g., program models, effective practices) for persons who are mentally ill and homeless or at risk of homelessness. The Substance Abuse and Mental Health Services Administration (SAMHSA) and its centers should continue their support of and expand current efforts to provide technical assistance in disseminating best and promising practices to the field.

- *Improve data and program planning*: Technical assistance should be made available to states to help them accurately and consistently estimate the number of individuals who are mentally ill and homeless or at risk of homelessness in their states. Program planning efforts at the local, state and national levels would be better informed as a result.

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Appendix

Position Statement of the National Association of State Mental Health Program Directors on Housing and Supports for People with Psychiatric Disabilities

National Association of State Mental Health Program Directors

POSITION STATEMENT ON HOUSING AND SUPPORTS FOR PEOPLE WITH PSYCHIATRIC DISABILITIES

The purpose of this position statement is to provide a framework to State Mental Health Agencies (SMHAs) to guide their housing policies and activities.

Housing Options

It should be possible for all people with psychiatric disabilities to have the option to live in decent, stable, affordable and safe housing that reflects consumer choice and available resources. These are settings that maximize opportunities for participation in the life of the community and promote self-care, wellness and citizenship. Housing options should not require time limits for moving to another housing option. People should not be required to change living situations or lose their place of residence if they are hospitalized. People should choose their housing arrangements from among those living environments available to the general public. State mental health authorities have the obligation to exercise leadership in the housing area, addressing housing and support needs and expanding affordable housing stock. This is a responsibility shared with consumers and one that requires coordination and negotiation of mutual roles of mental health authorities, public assistance and housing authorities, and the private sector.

Provision of Services

Necessary supports, including case management, on-site crisis interventions, and rehabilitation services, should be available at appropriate levels and for as long as needed by persons with psychiatric disabilities regardless of their choices of living arrangements. Services should be flexible, individualized and promote respect and dignity. Advocacy, community education and resource development should be continuous.

Adoption

Adoption of this position statement empowers the NASMHPD President's Task Force on Housing for

Persons with Psychiatric Disabilities to aggressively address the following:

- the need for State Mental Health Agencies to be provided with state-of-the-art resource materials/toolkits to help guide their efforts in developing housing for persons with psychiatric disabilities;

- the need to advise the Board of Directors and NASMHPD membership of the short- and long-term strategies necessary to respond to decreasing federal resources for affordable housing and federal policies which impede access to housing by people with psychiatric disabilities;

- the need to advise the Board of Directors and NASMHPD membership of the partnerships which can be formed with key national and state stakeholders to facilitate the development of affordable housing throughout the nation.

The Task Force will report to the Board of Directors and to the membership at large on a quarterly basis. Membership of the President's Task Force on Housing for Persons with Psychiatric Disabilities shall consist of persons appointed by the President.

Originally adopted by the NASMHPD Membership—December, 1987;
Revised and adopted by the NASMHPD Membershipp—July, 1996