Review of California's Program for the Homeless Mentally Disabled

Executive Summary

Georges Vernez, M. Audrey Burnam, Elizabeth A. McGlynn, Sally Trude, Brian S. Mittman
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February 1988

Prepared for the California Department of Mental Health

RAND
PREFACE

This report was prepared for the California State Department of Mental Health project, "Independent Performance Review of County Homeless Programs Operating with the Homeless Mentally Disabled Targeted Funds." The research was intended to assess the effectiveness of California's Program for the Homeless Mentally Disabled, determine the accountability of its funds, and describe the demographic and mental disorder characteristics of the persons it serves. The report presents results from a survey of homeless individuals and from telephone interviews with and case studies obtained from county officials and service providers during the summer and fall of 1987.

The report should be of interest to state and local policymakers, service delivery providers, and advocates who have to decide whether the Program merits continued financial support and who have to devise strategies for enhancing service delivery to the homeless mentally disabled. Researchers studying problems of the homeless or program implementation should also find the results and methodologies relevant.

The interpretations and conclusions contained herein are solely those of the authors and should not be construed as representing the opinions or policy of any county or agency of the State of California.

The work summarized here is described in more detail in the following RAND publication:

ACKNOWLEDGMENTS

We are indebted to the hundreds of homeless, state and county officials, and service providers whom we interviewed. They were generous with their time and shared insights from which this study benefited appreciably.

Mr. Walter Watson at the State Department of Mental Health oversaw the conduct of the study and assisted us with access to county officials and state reports.

In the four counties that participated in our case studies, we received unconditional support from their Mental Health Directors and Homeless Coordinators. They are, respectively, Marye L. Thomas, M.D., and Arnold Perkins in Alameda; Timothy P. Mullins and Ron P. Pierre in Orange; Captane P. Thomson, M.D., and Leal Abbott and Dan Frank in Yolo; and Roberto Quiroz and Frances Griffith in Los Angeles. They reviewed our drafts of their respective case studies and made useful comments and suggestions.

Others at The RAND Corporation made significant contributions. Judith Perlman and Anne Arrington directed and supervised the fieldwork for the surveys of the homeless. Five interviewers conducted the enumeration and survey of the homeless: Robert Aisley, Michael Heman, Jeff Siggins, Robin Strausberg, and Phillip Vizard. This team spent many hours in the dead of night looking for homeless persons on the streets, beaches, and riverbeds; they developed a real understanding and empathy for the homeless they interviewed.

Kenneth B. Wells, Paul Koegel, and Greer Sullivan made major contributions to the design of the homeless questionnaire and other significant contributions to the study.

Allan F. Abrahamse designed the sampling strategy for the surveys of the homeless; Joan W. Keesey, Lisa Meredith, and Phil Watson performed computer programming for the data analyses. Susan J. Bell helped conduct telephone interviews and tabulate their results, and Lois Davis helped with the Yolo County case study site visit.

Deborah R. Hensler, Richard H. Lamb, Peter Jacobson, and Gail L. Zellman reviewed and commented on the draft of the final report and made many useful suggestions that enhanced the final product.

We also wish to thank Mary E. Vaiana, who took a lengthy draft report, reorganized it, and helped communicate the study's findings more directly. Finally, we appreciate the careful editing of Judith Westbury and the excellent secretarial assistance provided by Jacqueline S. Bowens.
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I. INTRODUCTION

BACKGROUND

As almost daily headlines suggest, homelessness has emerged as a prominent public issue. Since 1980, the number of homeless persons has risen sharply. The concentration of homeless in shopping areas, parks, and beaches is affecting business and recreation, thus spurring public calls for government, at all levels, to address the problem. Providing even subsistence services for the homeless burdens charitable organizations and local governments, and communities are reluctant to accept shelters and housing designed to help.

Nor is homelessness a problem that time will solve: Numerous cases are not short-term. Some studies suggest that the average episode exceeds three years. Many are concerned that increased periods of homelessness will create a permanent underclass, one that cannot navigate the sea of procedures necessary to obtain entitlements benefits and social and medical services.

But among the most alarming characteristics of this growing population is its shift in composition. In addition to larger numbers of families with children, the homeless include an increasing proportion of persons who are mentally disabled—according to various estimates, 25 to 50 percent of the total homeless population.

Public response to the unique problems of the homeless mentally disabled (HMD) has generally been slow. The HMD are not excluded from shelter, soup kitchens, and other subsistence services provided by private and public agencies, and generally they have been treated like the rest of the homeless. However, the two groups differ in some important ways. Mental disorder often results in lifelong functional impairment that hampers the ability to be self-supportive or to live independently. Several authors have identified desirable features of service programs for the HMD (Gudeman and Shore, 1984; Bachrach, 1983). They include: a comprehensive range of services, special attention to making those services accessible, coordination and continuity of care, case management, outreach, and special programs for subpopulations.

California's Mental Health Services Act of 1985 (California State Legislature, 1985) is one of the first statewide programs designed to address these features; it is more commonly known as the Bronzan-Monjonnier Act and will hereinafter be referred to as the state HMD program. The HMD program has allocated $20 million annually to the
state's 58 counties to support a wide range of services, from basic needs to rehabilitation. It emphasizes outreach to the HMD, outreach to those "at risk" of becoming HMD, and coordination of care among community service agencies. Further, it encourages an individualized approach to provider delivery and HMD treatment that tailors services to the needs and unique progress of each individual.

Prior to this legislation, neither the state nor most counties had programs that specifically targeted the homeless mentally disabled; moreover, the counties had not delegated a lead agency to coordinate service delivery either to the homeless in general or to specific subgroups among them. However, a few counties had small programs operating in specific areas (e.g., Los Angeles Skid Row and downtown San Diego) and had established a "Homeless Task Force" to improve coordination of services among providers. These task forces often provided a forum for discussing the services needed to address the problems of the homeless and of the homeless mentally disabled. Although needs varied among counties, the major areas included:

- Benefits and service advocacy
- Case management
- Social skills service centers
- Food, clothing, and other basic needs
- Shelter and temporary housing
- Long-term residential facilities
- Administrative coordination.

To a great extent, the intent of the HMD program and its programmatic and service delivery guidelines reflect these needs.

Several features of the HMD legislation distinguish it from previous mental health legislation and from responses to the problem typical in other states. First, the Act assigned responsibility for administering the program to the State Department of Mental Health; other states, such as New York, have lodged their homeless programs within their Department of Social Services. Second, its preventive focus allowed funds to be used for mentally disabled persons who are "at risk" of becoming homeless. Third, it departed from the tradition of limiting mental health funds exclusively to mental health services; instead, it authorized a comprehensive range of services including food, clothing, shelter, and active outreach. Finally, it gave counties flexibility to tailor their programs according to their respective needs and preferred institutional arrangements.
PURPOSE AND LIMITATIONS OF THE STUDY

In 1986, the California State Legislature mandated an independent review of the HMD programs that the counties had established with the state's funds. This report describes the results of that review. Our major study objectives were to:

- Estimate the number and location of homeless persons; describe their demographic characteristics and their health, housing, and subsistence needs; and estimate the number of homeless with specific types of disabling mental illnesses.
- Identify and categorize the services provided to the HMD population with HMD funds.
- Identify the characteristics of persons served by the HMD program and types of services received by them.
- Analyze selected measures of performance.
- Discuss the findings as they relate to adequacy of funding, allocation of funds, appropriateness of service mix and subpopulation targeting, and service delivery improvements and effectiveness.

Our assessment of the HMD program has two important limitations. (1) When we began our data collection in July 1987, the county programs had been in existence for less than 18 months. Thus, the short-term level of performance we measured may not represent the level of performance that may ultimately be attained.

(2) Much of the information concerning programmatic activities was collected in telephone interviews or site visits with staff and other persons associated with the program. Our findings therefore largely reflect their experience with the program. The programs produced limited statistical data describing the aggregate level of activities, characteristics of clients served, and flows of client referrals.

RESEARCH STRATEGY

Our research strategy was designed to balance two conflicting study requirements: (1) to provide comprehensive and reliable data to the State Legislature on a broad range of policy issues, and (2) to do so under the time constraint of seven months. The strategy included:

1. A Survey of the Homeless Population to provide a count of the homeless and a profile of their demographics, location, and service needs, and of the presence of severe mental disorder. The survey was conducted in Alameda, Orange, and Yolo counties.
2. *Programmatic Case Studies* in Alameda, Orange, and Yolo counties and Los Angeles Skid Row to provide a detailed picture of how the HMD program had been implemented.

3. *Telephone Interviews* with county Mental Health Directors and Homeless Coordinators, service agencies’ directors, and advocates in 17 counties to identify the range and characteristics of services funded, service innovations, and coordination practices, and to elicit views about the effects of the county programs. We interviewed more than 200 persons.
II. RESULTS OF THE HOMELESS SURVEY

ESTIMATING THE NUMBER OF HOMELESS

Approach

To meet the needs of the HMD effectively, policymakers and planners must have the answers to three basic questions:

- How many homeless are there in each service area?
- How many of the homeless have severe mental disorders?
- What are the demographic characteristics, service needs, and patterns of service use of the HMD and other homeless people?

To answer these questions, we conducted a survey of the homeless in three counties—Alameda, Orange, and Yolo—and analyzed data from a prior survey of the homeless in the downtown Los Angeles Skid Row area.\(^1\) Ours is the first thorough, empirically based attempt to estimate the size of the total homeless population in any California county.

Our strategy\(^2\) was to:

1. divide the county into geographical areas (census blocks);
2. obtain estimates from local experts (county agency and shelter program directors, local police) about the probability of finding homeless individuals sleeping overnight in these blocks;
3. sample among all areas that had some reported probability of containing homeless persons; and
4. search sampled areas at night to count the homeless persons actually found. Our counts included adults and children currently staying in emergency shelters for the homeless (not in shelters for battered women and children) and those currently staying on the "streets."\(^3\)

We did not directly count people who are usually or episodically homeless but happened to be in hospitals, jails, single-room occupancy

---

\(^1\)We selected Los Angeles Skid Row to take advantage of a recent detailed and reliable profile (Farr et al., 1986) of the homeless there; furthermore, this area has the largest concentration of homeless in the state.

\(^2\)This strategy is modeled after a recent study of Chicago by Rossi et al. (1986).

\(^3\)The "streets" included back alleys, parks and campgrounds, vehicles, abandoned buildings, bus and train depots, all-night coffee shops and theaters, beaches, riverbeds, and along harbors.
hotels, or staying with family or friends at the time of the survey. However, we adjusted our estimates to include homeless persons who were likely to have been missed because they were temporarily housed on the survey night.

Our Estimates

We estimate that Alameda County has about 1,000 homeless persons on a given day and about 2,800 over a period of a year; Orange County about 1,000 on a given day and about 4,400 a year; and Yolo County about 100 on a given day and about 200 a year.

The annual estimates are much higher than the daily estimates because only a small proportion of the homeless population is continuously homeless during a year. Our results indicate that the population is extremely fluid, with people constantly moving in and out of it.

Our estimates are subject to several inherent sources of bias: (1) seasonal variation in the number of homeless, (2) our exclusion of those at risk of becoming homeless, (3) our decision to forgo counting homeless in census tracts and blocks that local “experts” believed would not contain homeless, and (4) absence of information about the growth rate of the homeless population. With the exception of seasonal variation, these biases are toward underestimation. Thus, our estimates should be considered the lower bound of the actual homeless populations in these counties.

ESTIMATING THE NUMBER OF SEVERELY MENTALLY DISABLED

The HMD legislation does not define mental disability, and there is little consensus about a precise operational definition that can be consistently applied across programs or studies. The best alternative for our purposes was to define our survey sample according to the presence of severe mental disorders. The disorders we included were major affective disorders (recurrent major depression or bipolar disorder) and schizophrenia.

Although we excluded primary substance abuse from our definition of mental disorder, we decided to separately identify and describe

---

4Counting this population was not feasible. Our estimates of annual prevalence of homelessness include persons who are episodically homeless and therefore cover one “at-risk” population. Those who have not yet become homeless, however, are not included in our estimates.
homeless persons with substance use disorders (where primary or comorbid with severe psychiatric disorders) for two reasons. First, there is a growing recognition that persons with severe mental disorders, especially those who are homeless, may simultaneously abuse alcohol or drugs—they are known as the dual diagnosed. Second, substance abuse is highly prevalent among the homeless (Koegel and Burnham, 1987; Fischer et al., 1986) and is associated with disability (Wells, Golding, and Burnham, forthcoming).

About 30 percent of the homeless populations in the three California counties and in Los Angeles Skid Row have severe mental disorders—schizophrenia, bipolar affective disorder, or major depression (see Table 1). We estimated the following numbers of homeless with severe mental disorders in the three counties:

- In Alameda County, 317 persons on a given night and 921 over a year;
- In Orange County, 252 persons on a given night and 1,155 over a year;
- In Yolo County, 34 on a given night and 105 over a year.

Table 1

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Across All 3 Counties</th>
<th>Alameda</th>
<th>Orange</th>
<th>Yolo</th>
<th>L.A. Skid Row</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe mental disorder</td>
<td>30</td>
<td>33</td>
<td>26</td>
<td>40</td>
<td>27</td>
</tr>
<tr>
<td>Major affective</td>
<td>22</td>
<td>24</td>
<td>19</td>
<td>31</td>
<td>18</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>11</td>
<td>16</td>
<td>7</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>69</td>
<td>82</td>
<td>55</td>
<td>87</td>
<td>69</td>
</tr>
<tr>
<td>Alcohol</td>
<td>57</td>
<td>66</td>
<td>45</td>
<td>82</td>
<td>63</td>
</tr>
<tr>
<td>Drugs</td>
<td>48</td>
<td>60</td>
<td>38</td>
<td>40</td>
<td>31</td>
</tr>
<tr>
<td>Dual (mental and substance)</td>
<td>22</td>
<td>28</td>
<td>14</td>
<td>37</td>
<td>19</td>
</tr>
</tbody>
</table>

To determine if our respondents had one of the three severe mental disorders mentioned above or substance use disorders, we gave them a short screening questionnaire, developed specifically for this study. The screener questions were drawn from the Diagnostic Interview Schedule (DIS), a detailed and highly structured survey interview that collects the information needed to determine lifetime and current diagnoses according to the American Psychiatric Association's Diagnostic and Statistical Manual, 3d ed. (DSM-III), 1980.
From 54 to 93 percent of the severely mentally disordered homeless (SMD) also have a history of substance abuse or dependence. Rates of substance use disorders are similarly high among homeless persons without severe mental disorders.

CHARACTERIZING THE HOMELESS

In a number of respects—for example, age distribution, marital status, and history in the armed forces—the SMD are similar to other homeless. Both groups are predominantly unmarried and under 45; about one in five has served in the armed forces.

Their subsistence patterns are also quite similar. Both groups most often sleep outdoors or in shelters, and less frequently in rented rooms or with friends or family. Like other homeless, the severely mentally disordered usually get their food from soup kitchens rather than from markets and restaurants.

Approximately 60 percent of the homeless, whether or not they have severe mental disorders, reported some type of contact with relatives in the last month. Although few homeless cited friends or relatives as primary sources of food, 14 to 36 percent had slept overnight with a relative or friend at least once in the past month, suggesting that relatives may provide a substantial degree of ongoing support.

There are, however, some significant differences between the severely mentally disordered and other homeless. Although homeless, with and without mental disorders, are predominantly male, the severely mentally disordered are more likely than other homeless to be women. They are also more likely to have trouble getting enough to eat, and they have greater functional disability (see Table 2). For example, they perceive themselves to be in poorer health. They have difficulty accomplishing simple tasks such as buying a bus ticket, getting help at an emergency room, and filling out applications for benefits. They are less likely to be married or working and have been without steady jobs for a longer time.

---

6The SMD referred to in this section are as defined above. Elsewhere in this report, we use the term homeless mentally disabled (HMD) to refer to the severely mentally disordered and other subgroups of individuals with chronic mental disability as generically used by the county departments of mental health and other providers of services.
Table 2
FUNCTIONAL CAPABILITY OF
THE HOMELESS
(In weighted percent)

<table>
<thead>
<tr>
<th>Function Characteristic</th>
<th>Across All 3 Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SMD</td>
</tr>
<tr>
<td>General health perception:</td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>18</td>
</tr>
<tr>
<td>Good</td>
<td>33</td>
</tr>
<tr>
<td>Fair</td>
<td>33</td>
</tr>
<tr>
<td>Poor</td>
<td>15</td>
</tr>
<tr>
<td>Instrumental skills, e.g., need help to:</td>
<td></td>
</tr>
<tr>
<td>Buy bus ticket</td>
<td>9</td>
</tr>
<tr>
<td>Get assistance at</td>
<td></td>
</tr>
<tr>
<td>emergency room</td>
<td>12</td>
</tr>
<tr>
<td>Find phone number</td>
<td>5</td>
</tr>
<tr>
<td>Take medication</td>
<td>5</td>
</tr>
<tr>
<td>Fill out application</td>
<td>13</td>
</tr>
<tr>
<td>Any one of the above</td>
<td>27</td>
</tr>
</tbody>
</table>

SERVICE USE

The proportion of SMD who received benefits and used mental health services was larger than that of the other homeless, but the severely mentally disordered were nevertheless greatly underserved. Only about one in eight received Social Security Disability Insurance (SSDI); fewer than one in four received Medi-Cal or Medicare; and three out of 100 received Veterans’ Administration benefits. Fewer than one-fourth of those with a mental disorder had received any mental health outpatient treatment in the past six months, and only about 15 percent reported taking prescribed medications for emotional or mental problems.

The mentally disordered more frequently reported health visits for substance abuse than did other homeless, even though rates of lifetime substance abuse among the two groups were similar. And more frequently than other homeless, the severely mentally disordered said they had a legal conservator or guardian; but the percentage across the three counties that we surveyed was still low—15 percent. More than half of
those with a mental disorder across all three counties reported a visit to a physical health clinic in the past six months; among the other homeless, only one-third reported such visits.

ASSISTING WITH ACCESS TO SERVICES

Because the HMD legislation emphasizes outreach and case management, we assessed the extent to which county programs were reaching the homeless through these two avenues. Outreach primarily involves engaging the HMD, either on the street or at facilities that provide services to the homeless, and encouraging them to seek the assistance they need. Case management involves orchestrating service delivery from various providers to help the HMD obtain subsistence services, shelter, entitlements, housing, and mental and physical health services.

In all three counties, the homeless were most likely to have received help with basic subsistence needs (shelter, food, clothing, or a place to clean up) rather than with other needs (such as applying for benefits, obtaining physical or mental health care, or managing their money) (see Table 3). And the SMD got help more often than other homeless. More than half of them received assistance with something; the proportion among the other homeless was less than half. We also found that if homeless persons had not received help, it was in large part because help had not been offered, not because they had refused it. And the mentally disordered were no more likely to have refused help than other homeless persons.

To assess the effects of case management, we asked respondents whether they had someone they could go to for help with services such as finding a place to sleep or getting to a health clinic or somewhere else they needed to go. In general, the SMD are slightly more likely than other homeless to have someone they can go to for assistance. However, the majority of both groups name a relative or friend—not program staff—as the person on whom they rely most often.
Table 3
ASSISTING THE HOMELESS WITH ACCESS TO SERVICES
(In weighted percent)

<table>
<thead>
<tr>
<th>Service Assistance</th>
<th>Across All 3 Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SMD</td>
</tr>
<tr>
<td>In the past month, program staff helped with:</td>
<td></td>
</tr>
<tr>
<td>Shelter/food/clothing/cleanup</td>
<td>48</td>
</tr>
<tr>
<td>Physical/mental health care</td>
<td>10</td>
</tr>
<tr>
<td>Applying for benefits/entitlements</td>
<td>13</td>
</tr>
<tr>
<td>Managing money</td>
<td>8</td>
</tr>
<tr>
<td>Something else</td>
<td>14</td>
</tr>
<tr>
<td>In the past month, help was not offered by program staff</td>
<td>41</td>
</tr>
<tr>
<td>In the past month, help was offered but not accepted</td>
<td>3</td>
</tr>
<tr>
<td>In the past month, total of no help received from program staff</td>
<td>44</td>
</tr>
<tr>
<td>Someone is there to help secure services:</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>47</td>
</tr>
<tr>
<td>Yes</td>
<td>53</td>
</tr>
<tr>
<td>Program staff</td>
<td>7</td>
</tr>
<tr>
<td>Legal conservator/guardian</td>
<td>0</td>
</tr>
<tr>
<td>Relative/friend</td>
<td>42</td>
</tr>
<tr>
<td>Someone else</td>
<td>4</td>
</tr>
</tbody>
</table>
III. HMD PROGRAMS IN 17 COUNTIES

One unique feature of the California HMD legislation was the flexibility it gave counties to tailor their programs according to their needs and preferred institutional arrangements. We draw on our telephone survey of 17 counties\(^1\) and our case studies to describe how the counties set service priorities, organized the delivery of services, and implemented their programs.

SERVICE PRIORITIES

The counties varied substantially in how they allocated HMD funds among the key services, but basically the allocation depended on three factors: (1) the size of the HMD allocation to the county; (2) the county's philosophy about how much assistance the HMD need to access services; and (3) the pre-existing service delivery network. HMD funds generally support new or net additions to services—with one significant exception. About one-third of the beds now available to the HMD existed before the HMD program. Most are located in shelters that continue to serve other homeless. However, HMD funding assures the HMD priority access to these beds.

The counties implemented one of two major service strategies:

- The seven most populated counties in the state put in place a combination of three primary services: (a) outreach and/or case management services; (b) drop-in/socialization services; and (c) shelter, crisis, and transitional residential services.
- Smaller counties generally chose to emphasize one service area, relying on existing providers to furnish a continuum of services. Most of these counties focused their efforts on outreach and case management, seeking to facilitate access of the HMD to existing social and mental health services.

Smaller counties generally did not fund drop-in socialization services, although in a few counties (e.g., Sonoma, Yolo, and Mendocino) the HMD already had access to pre-existing services of this kind. Only

\(^1\) The 17 counties were selected to obtain variation in (1) population size and ethnic composition, (2) programmatic approaches and emphases, (3) service priorities, and (4) institutional arrangements for HMD services. See Table 4 below for a list of the counties selected.
two counties, Santa Clara and Alameda, funded advocacy programs to help the HMD access entitlement and housing services, and only Sonoma used HMD funds to provide vocational rehabilitation services.

Figure 1 shows how the counties allocated HMD funds across the three major service areas.

Overall more than 800 beds have become available to the HMD in the 17 counties surveyed (see Table 4). About 45 percent of these beds are in shelter settings, 30 percent in transitional facilities, and the balance in crisis, long-term, and independent residential settings. Los Angeles County accounts for a third of the beds, and the next six largest counties in the state for nearly all other beds. Most smaller counties provide vouchers for short-term stays in existing shelters, hotels, and motels.

Fig. 1—Allocation of HMD funds across major program areas
Table 4

NUMBER OF HMD-FUNDED BEDS

<table>
<thead>
<tr>
<th>Type of Residence</th>
<th>County</th>
<th>Shelter</th>
<th>Crisis</th>
<th>Transitional</th>
<th>Long-Term</th>
<th>Living</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive</td>
<td>Los Angeles</td>
<td>78</td>
<td>20</td>
<td>85</td>
<td>63</td>
<td>33</td>
<td>279</td>
</tr>
<tr>
<td>or Independent</td>
<td>San Diego</td>
<td>55^a</td>
<td>14</td>
<td>40</td>
<td>—</td>
<td>—</td>
<td>112</td>
</tr>
<tr>
<td></td>
<td>Orange</td>
<td>40^a</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Santa Clara</td>
<td>55</td>
<td>—</td>
<td>20</td>
<td>—</td>
<td>57</td>
<td>132</td>
</tr>
<tr>
<td></td>
<td>Alameda</td>
<td>72</td>
<td>—</td>
<td>12</td>
<td>—</td>
<td>—</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>San Bernardino</td>
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<tr>
<td></td>
<td>Sacramento</td>
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<td>14^b</td>
<td>51</td>
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<td>San Francisco</td>
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<tr>
<td></td>
<td>Ventura</td>
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<td>Fresno</td>
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<tr>
<td></td>
<td>Butte^c</td>
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<td></td>
<td>Yolo^c</td>
<td>9^a</td>
<td>—</td>
<td>—</td>
<td>—</td>
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<td>9</td>
</tr>
<tr>
<td></td>
<td>Mendocino^c</td>
<td>—</td>
<td>—</td>
<td>3^d</td>
<td>—</td>
<td>—</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Tehama^c</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>Mariposa^c</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
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<td></td>
<td>Total</td>
<td>370</td>
<td>48</td>
<td>265</td>
<td>63</td>
<td>96</td>
<td>842</td>
</tr>
</tbody>
</table>

SOURCES: County applications and telephone interviews.

NOTE: Counties are listed in decreasing order of population size.

^aIncludes reserved beds in shelters open to all homeless.

^bShort-term unlicensed facilities.

^cAlso use vouchers for placements in motels/hotels as needed.

^dTwo transitional apartments totaling three beds.

SERVICE DELIVERY

The pre-existing service delivery networks and the county’s philosophy about whether services should be contracted out are the most significant influences on the institutional arrangements for service delivery that we observed across counties. These arrangements vary along two important dimensions: (1) the approaches to serving individual clients and (2) the degree of reliance on contractors.
We identified three basic approaches that counties use to serve individual clients.

1. **The joint outreach/case management model** combines within one individual the responsibility for engaging clients, assessing their needs, referring them to services, and ensuring that they receive the services they need and want. This approach basically reflects a social work model of managing delivery of services to an individual client: The outreach/case management staff are responsible for orchestrating service delivery from the various providers to their clients. The approach is often characterized by a low caseload per worker—10 to 20—and, in the larger counties, extensive follow-up of clients, often including transporting clients to services and encouraging their use of a drop-in center.

When a client is accepted for treatment by a county mental health office, that office usually assumes responsibility for managing the case. Sometimes, however, the outreach/case manager may remain with the case even while mental health treatment services are being provided. Over time, the cumulative caseload of these managers may become burdensome.

2. **The separate outreach and case management model** divorces the two functions. The outreach worker's responsibility is to engage the HMD and refer them as quickly as possible to mental health service providers. Once referred, the cases are routinely managed by county mental health.

3. **The provider-oriented model** relies primarily on a group of specialized service providers. Any outreach is provided separately by and for each individual provider; case management, if it is provided, is generally limited to assessment, referral, and follow-up services furnished by each provider. The caseload per manager generally varies between 30 and 40. Continuity of services generally requires that the client continue to frequent the provider.

All three approaches involve preparing a written service plan for each client, usually a one-page checklist of services needed and a space available to write in whether the service was eventually provided. Involvement of relatives or service providers in service plan preparation is rare. Service staff often indicated that the HMD have no relatives or will not give permission, or the necessary information, to involve them.

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2Contracted providers in at least two counties deliver a comprehensive range of services.

3One exception is in Santa Clara County. Here the HMD program works on an ongoing basis with family members while it is assisting their mentally disabled relatives when they may be on the street.
The approaches vary with respect to the continuity of case management and to the comprehensiveness of the services included in the case management function. Whatever the approach, however, the programs provide limited continuity in case management—in part because of resource constraints and in part because of the difficulties inherent in serving a mobile, unstable, and chronically ill population.

Case management and outreach are often the only services that counties provide directly, in part because these are the services with which county mental health departments have experience. Most services are provided through contract agencies, and consistent with legislative intent, counties generally select contractors who are already operating in their area. The majority of these are large, well-established social service agencies with considerable experience in serving either the homeless in general or the mentally ill. Few new provider agencies were created as a result of HMD funds.

A profile of the average contract agency:

- In operation for nearly 20 years.
- Budget of $500,000 to $1 million per year.
- Components of budget: 20 percent from HMD funds; 20 percent from private donations; 60 percent from other government contracts, including county mental health department and federal housing programs.
- More than two-thirds of services provided are new, not expansions of previous services.
- Outreach, socialization, and crisis/transitional residential services to the HMD population are generally run separately from other agency services.
- In shelters which served and continue to serve all homeless, HMD funds are used to enhance services to the HMD population.

**ORGANIZATION AND MANAGEMENT**

As a result of the HMD program, almost every county department of mental health has designated a single individual to function as its Homeless Coordinator. Typically, the HMD coordinator monitors contracts, provides consultation and advice to contractors, does some training, and supervises in-house programs. In the smallest counties, the HMD coordinator operates the entire program directly. In general, the coordinator has good access to the county director of the mental health department—in most counties, the coordinator reports to one of the department's deputy directors.
For the most part, there are no formal training programs for those working with the HMD. However, counties are currently using a range of informal training activities and some are planning more formal programs.

REPORTING REQUIREMENTS

During the start-up period for the HMD program, both the state and the counties assigned first priority to putting services into operation. Accountability for funds and services was considered later. As a consequence, current state reporting requirements are minimal. They consist of:

1. A quarterly report to the state summarizing units of service provided and number of individuals served over a one-week period. The first report was requested for a one-week period in December 1986, and subsequent reports were filed in March and June of 1987.

2. Yearly visits of state operations staff to HMD service providers, intended to identify major implementation problems and funding issues.

3. On-site observations of HMD service providers by county staff, usually the Homeless Coordinator. These are intended to help providers resolve problems.

These reports and visits do not generate enough information at either the county or the state level for managers to determine in real time the status of the counties’ HMD activities. Even more important for a program that emphasizes individualized service planning and delivery, the current reporting requirements limit the ability of case managers to track the status of each case in the service delivery/treatment continuum. Although charts are usually opened on each individual, there is no consistency at the state level—and usually not at the county level—about what information is kept or about how to annotate or report the progress of a case. The individual service providers and, consequently, the counties and the state have no ready

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4There is at least one significant exception to these reporting patterns. Los Angeles County has fully integrated the reporting requirements for its program into its Management Information System. The county has overcome initial difficulties familiarizing other social agencies with department of mental health terminology and service reporting and coding requirements. However, this system still does not enable a case manager to track the service and treatment of an individual client. Once a client moves into a permanent residence or begins to use only services that are not HMD-funded, his/her file loses its affiliation with the HMD program.
means of aggregating data to provide ongoing profiles of the clients they serve, the referrals and placements they make, or the clients with whom they lose contact.

Designing appropriate reporting requirements for the HMD program is not a simple issue. The program staff we interviewed valued the flexibility provided by the minimal reporting requirements. Many HMD feel threatened when asked questions about themselves, their past, and their way of life. The staff also feel that minimizing information gathering increases the time they have available to engage and serve the HMD. However, these concerns will have to be balanced against the information needed for successful program management and for assessing the effects of the counties' alternative approaches to serving the HMD.

IMPLEMENTATION PROGRESS

Implementation of county HMD programs began in earnest in January 1986. Not surprisingly, by the end of that fiscal year, less than 50 percent of the $20 million allocation for FY 1985–86 had been spent.

Delays in implementing the programs came from a variety of sources. Many counties experienced difficulties in locating facilities or sites for new programs. Community opposition and other factors often led to difficulties in obtaining facility licenses or permits required by local governments. In addition, there were often delays in constructing or rehabilitating facilities once proper approvals had been obtained. A few counties experienced difficulties in the contracting process, including protests and formal appeals.

Other sources of delay reported by counties included difficulties obtaining liability insurance and recruiting and hiring staff. Hiring delays, however, were relatively minor compared with facility problems. Shortages of qualified personnel and high turnover rates also affected a few programs.

For the most part, and with the notable exception of local opposition to siting new facilities, these delays were absent in the second year of spending. In FY 1986–87, only Ventura County failed to spend more than half of its allocation, and half of the counties surveyed spent their entire amount. As of late 1987, all 17 counties reported that their programs were largely operational—in 12, fully operational.

Obtaining permits for new facilities remains a problem. San Diego, Orange, Santa Clara, Los Angeles, and Alameda counties report that some drop-in centers, shelters, or other residential programs are still
not operational. Counties are attempting to circumvent the permit problem by reducing the size of the proposed new facilities or by using existing facilities for which they do not need new permits.
IV. SELECTED RESEARCH RESULTS

This study was not designed to determine which of the service delivery strategies and institutional arrangements are most effective. Answering this question would require following a sample of individual HMD over time in a number of counties that vary in service delivery and case management practices. However, we did seek to determine the extent that the counties' programs, in the aggregate, were successful in providing engaged clients with (1) subsistence services—i.e., food, clothing, and shelter; (2) entitlement benefits; (3) mental health treatment services; and (4) assisted or independent permanent housing arrangements. Data limitations hampered our efforts: Some counties do not keep the necessary data, others cannot easily retrieve them. When data are available, they are often not readily-comparable across agencies or counties. Thus, our assessment should be viewed as preliminary.

SERVICE USE

Subsistence Services

County programs appeared to be most effective at providing basic necessities including food, clothing, and shelter. Overall, 60 to 70 percent of the units of service provided to the HMD were for subsistence services, reflecting the priority that nearly all counties placed on them. Of the surveyed HMD who reported receiving some help from any service staff, more than 80 percent said that the help had been with subsistence services.

Entitlements

Outreach workers and case managers assigned high priority to helping the HMD obtain General Assistance or Supplemental Security Income (SSI) because a steady income is often a prerequisite for obtaining some form of permanent housing and because a majority of the HMD do not receive any of these benefits. Nearly all our service staff respondents noted how time-consuming the application process is for both SSI and General Assistance, how high the rejection rate is for first-time applications, and how high the likelihood is that clients might not be able to secure continuing benefits because of periodic
verification requirements. For clients unable to manage on their own, inadequate funding for or unavailability of representative payees presents additional barriers to entitlements. Staff told us that dual diagnosed clients are particularly susceptible to this constraint because of their history of "mismaneaging" funds through excessive expenditure on drugs and/or alcohol. To alleviate this problem, a number of counties have developed a modest capacity for managing money and/or functioning as representative payee.

Mental Health Services

Although counties are authorized to use HMD funds to provide certain mental health treatment services—including day, outpatient, and specific 24-hour services\(^1\)—very few used HMD funds to provide mental health services to the HMD.

Table 5 shows the number of mental health service units provided with HMD funds during a one-week period in March and another in June 1987. Los Angeles County accounts for the majority of services. It provided about 80 percent of the HMD-funded medication and 50 percent of the 24-hour care units. A handful of counties accounts for the remainder. For day services, primarily socialization services, the next five largest counties account for most of the remaining service units. For mental health outpatient services, the main counties using HMD funds were Santa Clara and San Francisco. For 24-hour care, they were Sacramento and San Mateo.

The county departments of mental health could provide little or no information regarding the extent to which they used other funds (including Medi-Cal, Medicare, or Short-Doyle\(^2\)) to provide mental health services to clients referred to them through HMD program activities. Nearly all counties indicated some capacity constraints in their mental health system, stressing that more beds were needed for inpatient, crisis, and transitional residential facilities. The estimated number of inpatient beds needed ranged from three in the smaller

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\(^1\)The following services are not fundable by the HMD program: state and local hospitals, psychiatric health facilities, skilled nursing facility (SNF) intensive services, jail inpatient services, collateral services, and individual and group therapy. Most of these services focus on inpatient treatment. All other mental health services are fundable by the HMD program.

\(^2\)The State of California Short-Doyle Act was passed in 1957. It and its subsequent amendments define the mental health services that qualify for state reimbursement, the matching formula for reimbursement, and the administrative requirements for county delivery of mental health services. The Act emphasizes early, close-to-home, nonhospital treatment services and provides the means for prevention of psychiatric disorder through education and consultation to caregiving agencies in the community.
Table 5
HMD-FUNDED MENTAL HEALTH SERVICE UNITS BY SIZE OF COUNTIES, MARCH AND JUNE 1987

<table>
<thead>
<tr>
<th>Population of Counties (No. of counties)</th>
<th>Medication</th>
<th>Day Services¹</th>
<th>Outpatient Services¹</th>
<th>24-Hour Care²</th>
<th>Involuntary Hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>March</td>
<td>June</td>
<td>March</td>
<td>June</td>
<td>March</td>
</tr>
<tr>
<td>3+ million (1)</td>
<td>672</td>
<td>622</td>
<td>606</td>
<td>866</td>
<td>222</td>
</tr>
<tr>
<td>1-3 million (5)</td>
<td>60</td>
<td>24</td>
<td>603</td>
<td>387</td>
<td>65</td>
</tr>
<tr>
<td>0.5-1 million (7)</td>
<td>67</td>
<td>69</td>
<td>7</td>
<td>6</td>
<td>87</td>
</tr>
<tr>
<td>All others (43)</td>
<td>82</td>
<td>60</td>
<td>117</td>
<td>65</td>
<td>79</td>
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<tr>
<td>Total</td>
<td>861</td>
<td>775</td>
<td>1333</td>
<td>1324</td>
<td>453</td>
</tr>
</tbody>
</table>

SOURCE: Counties’ reports to the State Department of Mental Health.

NOTE: Figures in this table are for the weeks of March 23-29, 1987, and June 22-28, 1987. Ten counties—representing $600,000 in HMD funds—did not file a report in March, whereas 22 counties—representing $4,000,000 in HMD funds—failed to report in June. Thus, comparisons over time should not be made.

¹Day services consist primarily of socialization services, but may also include vocational services and day care intensive and rehabilitative services.

²Includes assessment and crisis intervention. Excludes individual and group therapy.

³Excludes hospitals, psychiatric health facilities, SNF intensive services, and jail inpatient services.

counties to 300 in the larger counties; the estimates for transitional beds ranged from two in smaller counties to 400 in larger counties.

Long-Term Housing

Permanent placement of the HMD in assisted or independent living arrangements is the state’s ultimate program goal. Counties reported one placement in board and care for every 50 persons served during a given week, but they could provide neither actual figures nor estimates of placements in independent or other types of housing. Most indicated that few of these placements were made. Reasons given were the lack of low-income housing, particularly in the larger counties, and the need for additional long-term beds, from 20 in smaller counties to 500 in larger counties.
ENGAGING THE HMD

For the HMD, outreach is often the door to services. Fifteen of the 17 counties surveyed engage in some form of outreach to the HMD and allocate 10 to 70 percent of their HMD funds for that activity. The major outreach activities, in roughly decreasing order of importance, are:

- **Responses to referrals** from service agencies, entitlement program eligibility workers, discharge planners at jails, hospitals, mental health residential facilities, board-and-care operators, and the community.
- **Active agency outreach**—approaching an individual at facilities providing unconditional services to the homeless.
- **Active street outreach**—engaging individuals in public or accessible areas. The approach is made without knowing the individual’s living arrangements or mental health status.
- **Outstationing** at offices, primarily SSI and General Assistance, to help mentally disabled clients complete forms and to link them to other services.
- **Crisis intervention**—responding to calls about crisis situations from service agencies or individuals. This approach may be closely linked with the involuntary hospitalization process.

All of the counties providing outreach services employ some combination of street outreach, agency referrals, and self-referral. With few exceptions, street outreach constitutes from 10 to 25 percent of the outreach contacts made. The remainder of the outreach effort consists of seeking HMD individuals at other service providers or through referrals from other agencies. Nearly half of the counties operate their outreach efforts from drop-in centers.

The process of engaging HMD was described in similar terms by many of the outreach workers interviewed. A typical scenario:

I might encounter someone on the streets in a doorway, or in the line of a soup kitchen. If he/she seems receptive I try and build rapport, first trying to find out what his/her situation is. I give them something they might need, such as some food or toiletries. Sometimes, we might go someplace together to eat so we can be alone to talk. If they’re still receptive, and depending on their needs, I might transport them to a drop-in center, clinic, or shelter and work out shelter arrangements. If an individual is not receptive, it might be a matter of just saying “hi,” and bringing them something (I’ll try different things), until I become familiar. What services I provide depends on what they want or need. After regular contact is established, the next step might be getting them on General Assistance, and into
some kind of housing arrangement. They almost always will accept food and shelter, but are less willing to accept mental health services.

A typical outreach contact involves engaging the client, offering a range of services without requiring acceptance of mental health services, and working with the client until the living situation is stabilized. All of the counties use their outreach effort to link the HMD to a range of providers. After engaging an individual, these outreach teams help him/her to obtain basic services such as food, clothing, and shelter. Many transport the individual directly to other service providers; others furnish bus tokens. The outreach team also helps the individual to obtain General Assistance and Social Security benefits.

County officials and outreach staff identified a variety of factors that contribute to successful outreach and continuity of service. In general, they attributed success to the outreach worker’s ability to “beat” the streets and to build trust and rapport with clients by being aggressive but not threatening, sensitive yet assertive. The factors cited by our respondents include:

Staffing
- Personal experience with street life and/or homelessness
- Strong clinical skills
- Training, i.e., in engagement techniques and how to respond to hostility
- Education of staff in other agencies
- Dedicated and resourceful personalities
- Experience with drug or alcohol abuse counseling and/or treatment
- Supportive supervisory staff

Approach
- Nonthreatening, low profile
- Minimizing association with involuntary commitment process
- Minimizing reporting requirements

Service availability
- Access/availability of drop-in/socialization center
- Access to transportation
- Proximity of service providers
- Ability to assist in obtaining General Assistance or SSI benefits

All of the counties minimize the use of involuntary commitment. Evidence suggests that most HMD can be engaged effectively by
outreach activities, and that a majority will voluntarily accept services. However, an estimated few to 30 percent of the HMD refuse services even after repeated attempts to engage them. Factors associated with the hard-to-reach include severity of mental illness, substance abuse, length of homelessness, transience, and types of services being offered—especially mental health services.

**TARGETING THE HMD**

County programs focus primarily on the currently homeless, rather than on the at-risk population. A majority of the mentally disabled served are also substance abusers, that is, dual diagnosed (see Table 6).

Outreach services focus on the severely mentally disabled. In contrast, less than half of those receiving shelter and drop-in services are described as severely mentally disabled. This may reflect in part the

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### Table 6

**CHARACTERISTICS OF POPULATION SERVED BY HMD PROGRAMS, BY TYPE OF SERVICE**

<table>
<thead>
<tr>
<th>Characteristics of Population Served</th>
<th>Services</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outreach</td>
<td>Drop-in</td>
<td>Shelter</td>
<td>Transitional Residential</td>
</tr>
<tr>
<td>Percent homeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>86</td>
<td>82</td>
<td>95</td>
<td>64</td>
</tr>
<tr>
<td>Range</td>
<td>75–100</td>
<td>80–90</td>
<td>90–100</td>
<td>25–100</td>
</tr>
<tr>
<td>Percent severely mentally disabled</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>84</td>
<td>45</td>
<td>42</td>
<td>90</td>
</tr>
<tr>
<td>Range</td>
<td>30–100</td>
<td>10–70</td>
<td>15–80</td>
<td>75–100</td>
</tr>
<tr>
<td>Percent dual diagnosed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>54</td>
<td>57</td>
<td>55</td>
<td>70</td>
</tr>
<tr>
<td>Range</td>
<td>15–85</td>
<td>30–70</td>
<td>10–85</td>
<td>45–100</td>
</tr>
</tbody>
</table>

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3Generally, outreach staff defined "refusal" to mean their own inability, after several attempts, to convince an individual to accept a managed approach to service delivery. Under this definition, refusal does not imply that the hard-to-reach refuse all services. As one outreach worker noted, "Almost no one refuses a sandwich." Nor does it imply that the HMD might not use soup kitchens or shelter services on their own.
higher level of functioning of the moderately mentally disabled, who may access these services more readily on their own. It may also reflect the difficulties that shelter and drop-in operators say they have in serving a concentration of severely mentally disabled, some of whom have unusual behavior and may be disruptive.

Shelter, drop-in, and outreach services assist fewer of the dual diagnosed (about 50 percent) than is found among the HMD population (70 percent). Service providers, most particularly those with a social services background, indicate that they find it extremely difficult to serve this subgroup because they lack experience in dealing with substance abuse and because rehabilitation services are difficult for this population to access.

SERVICE COORDINATION AND LINKAGES

The state HMD funding has improved coordination among counties and among service providers. For example, the Homeless Fairs held across the state provide informal occasions for representatives of mental health facilities, homeless programs, private agencies, and homeless activist organizations to exchange information. Workshops and seminars have also helped county representatives meet and exchange information on specific programs and approaches. Within counties, the activities of the Homeless Coordinator, regular meetings of the providers with the Homeless Coordinator, and case referrals among providers have improved interagency coordination. However, the state program has generally not encouraged the development of new ways to serve this population. Rather, it has expanded existing services and helped the HMD to access them.
V. DISCUSSION

Overall, we found that the HMD-funded programs implemented by the counties meet the intent of the State Legislature by providing new or expanded services to the homeless mentally disabled. Each county uses the flexibility provided by the legislation to set service priorities and to implement service delivery systems that best fit its own circumstances—in particular, its level of funding, its pre-existing service network, and its basic philosophy about how much help the HMD need to access services. Although the mix of services varies across the counties, the programs emphasize the provision of subsistence services (e.g., food, clothing, shelter), drop-in or socialization services, and assistance in obtaining entitlement benefits.

Despite these achievements, significant gaps remain in the amount and types of services available to the HMD:

- The most severely mentally disabled and the mentally disabled who are currently abusing alcohol or drugs are underserved.
- The hard-to-reach HMD and the mentally disabled at risk of homelessness are underserved.
- A complete continuum of services is not available; the most important gap is the lack of appropriate alternative housing arrangements.

UNDERSERVED GROUPS OF HMD

Severely Mentally Disabled HMD

Table 7, drawn from our three-county survey of homeless individuals, shows that the gap between needs and service use is substantial for the severely mentally disordered homeless.

- More than one in three of the severely mentally disordered say that they usually or sometimes do not get enough to eat on a daily basis.
- More than half have had to sleep outdoors at least once in the past month, and almost half have no one to go to for help in obtaining services.
- More than two out of three have a history of drug or alcohol abuse.
### Table 7

**GAPS BETWEEN NEEDS AND SERVICES FOR SEVERELY MENTALLY DISORDERED HOMELESS**

<table>
<thead>
<tr>
<th>Service Category</th>
<th>SMD (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs as indicated by:</td>
<td></td>
</tr>
<tr>
<td>Trouble getting enough to eat, usually/sometimes</td>
<td>39</td>
</tr>
<tr>
<td>Fair or poor health</td>
<td>48</td>
</tr>
<tr>
<td>Abuse of substances</td>
<td>73</td>
</tr>
<tr>
<td>Sleeping outdoors in the past month</td>
<td>62</td>
</tr>
<tr>
<td>No one to go to for help in obtaining services</td>
<td>47</td>
</tr>
<tr>
<td>Entitlements, benefits:</td>
<td></td>
</tr>
<tr>
<td>SSI/SSDI</td>
<td>12</td>
</tr>
<tr>
<td>General Assistance/welfare</td>
<td>25</td>
</tr>
<tr>
<td>Veterans’ benefits</td>
<td>3</td>
</tr>
<tr>
<td>Medi-Cal/Medicare</td>
<td>22</td>
</tr>
<tr>
<td>Occurred in last 6 months:</td>
<td></td>
</tr>
<tr>
<td>Mental health visit</td>
<td>20</td>
</tr>
<tr>
<td>Mental health medication use</td>
<td>15</td>
</tr>
<tr>
<td>Substance abuse visit</td>
<td>18</td>
</tr>
<tr>
<td>Mental health hospitalization in last 12 months</td>
<td>7</td>
</tr>
</tbody>
</table>

- Nearly half rate themselves to be in only fair or poor health.
- About one out of eight receives SSI and one out of four receives state welfare income.
- Only about one out of five currently participates in Medi-Cal or Medicare programs.
- Only about one out of five has had any outpatient visits for mental health or substance abuse reasons or has used medications for mental health problems in the past six months.
- Fewer than one in ten were hospitalized for mental health problems in the past year.

This gap between needs and services does not appear to be the result of ineffective service targeting. HMD service providers in the counties we surveyed do target and serve the HMD and those “at risk.” On average, from 64 to 85 percent of the clients served are homeless, and
from 67 to 100 percent (depending on the service) are mentally disabled. Clearly, services are being provided to the intended population.

It appears that many HMD are not being served because needs exceed capacity. Numerous service providers, especially in the larger counties, reported that they were currently operating at or near capacity. Outreach workers estimated that they could not reach from 5 to 60 percent of the HMD because of constraints in outreach capacity. From 40 to 45 percent of the HMD we surveyed reported that they had no contact with any outreach activities and/or had received no help from service delivery staff, either for subsistence services or for entitlements. A somewhat larger proportion, 60 to 70 percent, of the homeless who were not mentally disabled had also received no such help.

Dual Diagnosed HMD

A majority of the severely mentally disabled are also substance abusers. Program staff gave four reasons why they are unable to serve this population.

- The HMD program legislation prohibits using funds for serving substance abusers unless the diagnosis is secondary, and does not provide funding for treatment of substance abuse.
- The dual diagnosed HMD have limited access to county mental health and substance abuse treatment services because these providers have limited capacity and weak interagency relationships.
- Substance abuse may exacerbate a psychiatric disorder, making the individual more resistant to treatment.
- Neither substance abuse nor mental health treatment programs are currently designed to provide the special treatment needed by the dual diagnosed.

In view of the importance of this issue, we suggest that the state establish a task force to review the problem and recommend ways to address it.

Hard-to-Reach HMD

A third subpopulation not being served is the small group of HMD who will not accept a managed approach to service delivery. These individuals were often characterized as the “most severely mentally disabled” and those who had been homeless for long periods.

We asked program staff what should be done to engage this resistant subgroup. Some respondents expressed the belief that with patience
and repeated contacts over an extended period—six months or more—even these individuals could be convinced to accept services voluntarily. Others indicated that the HMD who resist placement in the generally restricted residential settings offered by mental health and board-and-care homes might be more responsive to placement in less restricted residential accommodations.

Most program staff, often reluctantly, suggested that making involuntary commitment easier is both desirable and necessary. They cautioned, however, that such a measure must be accompanied (1) by an extension of the initial maximum period of commitment to allow for full stabilization of the individual before release and (2) by an increase in the available number of hospital, crisis, or transitional beds. In addition, staff also noted the need to establish or expand the temporary conservatorship program to help individuals discharged from hospitals or transitional facilities manage their affairs while in the community.

The At-Risk

A fourth underserved group consists of the mentally disabled at risk of homelessness. With few exceptions, HMD-funded programs have focused their resources on serving the currently homeless. In part, this de-emphasis on prevention derives from the difficulties in identifying and tracking the at-risk population. Large and diversified, this population includes:

- individuals living with relatives, who may eventually expend their reserve of tolerance;
- those living in board-and-care homes who may be on the verge of eviction for not paying the rent or for being disruptive, or who may simply yearn for the sense of mastery that accompanies living independently;
- those living independently, but vulnerable to the sometimes demanding recertification or other administrative requirements for SSI, General Assistance, and Medi-Cal; and
- those about to be discharged from jails; state, county, or private hospitals; or crisis or transitional residential facilities.

The Los Angeles Skid Row data suggest that approximately 70 percent of the homeless are episodically homeless. Thus, the formerly homeless are an important subgroup of the at-risk population that can be targeted to break the cycle of homelessness. But identification of and ongoing case management for this at-risk population are expensive because they require regular contact with the clients and those surrounding them, whether or not there is a current problem.
Computer technology may help case managers monitor the status of those at risk and coordinate the services a client receives from different agencies. On-line exchanges of information about a client's service needs, level of functioning, medications, social and financial resources, and living arrangements could enable a case manager to track that client; if circumstances or requirements appeared to threaten financial resources or the stability of a living situation, the case manager could intervene appropriately to prevent a crisis that might result in homelessness. With appropriate procedures to protect privacy, counties could experiment with information technology to evaluate its feasibility and costs and to assess its potential usefulness.

GAPS IN CONTINUITY OF CARE

Most of the severely mentally disabled require a lifetime of wide-ranging treatment and supportive services. County officials and service providers identified four basic reasons why the counties cannot provide individual HMD with the continuum of services they need.

- Limited ability of programs to link the HMD with ongoing mental health services because of capacity constraints.
- Lack of appropriate alternative housing arrangements.
- Ongoing difficulties in obtaining and maintaining entitlement benefits, which are critical for supporting a permanent residence in the community.
- Limited ability of case managers to follow cases.

Mental Health Services. Capacity constraints limit the ability of programs to link the HMD with ongoing mental health services. In response, counties have either implemented HMD programs parallel to the existing mental health system, or they have tried to integrate the two systems. In the former case, providers in the two systems interact only in a crisis—for example, a suicide attempt. In the latter, staff are increasingly aware that they must make trade-offs between the numbers of clients served and the level of service provided and/or among differently diagnosed groups of the mentally disabled.

Alternative Housing Arrangements. The counties lack appropriate alternative housing arrangements. The nature of chronic mental illness limits the ability of those it afflicts to live completely independently. Also, their housing needs may change, and board-and-care facilities that are acceptable during some periods of their lives may become unacceptable at other times. The available residential alternatives offer a stark choice between entirely independent living
and group residential facilities that typically require abiding by many rules. Staff in many counties suggested a need for additional housing arrangements—in most cases, independent apartment-style living with a built-in support system designed to provide assistance in times of crisis. Although still largely untested, these residential arrangements may offer greater capacity for self-reliance and privacy as well as more intensive support than board-and-care facilities do.

Entitlement Benefits. The severely mentally ill homeless find it difficult to obtain and maintain the entitlement benefits they need to support a permanent residence in the community. Our study shows that of all the SMD:

- only 12 percent were receiving SSI or SSDI,
- 25 percent were receiving General Assistance benefits,
- 3 percent were receiving Veterans’ Administration benefits,
- 22 percent were receiving Medicare or Medi-Cal.

Obtaining eligibility for most of the programs is both complex and time-consuming, and maintaining it requires frequent recertification. Several of the counties have used innovative approaches to help individuals obtain and maintain entitlement benefits—for example, educating agency staff to identify and work with the mentally disabled, funding advocacy groups to help individuals navigate the complex application process, and providing money management.

Case Management. The amount and type of assistance that individuals with chronic and severe mental disorders may require will vary and will depend on the severity of the disorder, the history of treatment, and the adaptation of the individual to the disorder. Most persons will require more intensive services during crisis periods, which can be stimulated either by the disorder itself (e.g., an acute psychotic episode) or by problems in daily living (e.g., recertification hearing by SSI, threatened eviction). These crises may precipitate an episode of homelessness unless the individual is linked with a support system that can mediate the crisis.

At best, the county HMD programs provided limited continuity in case management because of the difficulties inherent in serving a mobile, unstable, and chronically ill population, and because of resource constraints. County staff indicated that if additional funds were available, expanding case management would have priority second only to housing. We believe that expanding case management might have limited impact if several complementary issues are not simultaneously addressed: the low pay and high attrition rate for outreach/case management staff; limited training and experience of the
staff; and the need to develop better techniques for client tracking and follow-up.

IMPROVING SERVICE DELIVERY

Perhaps the most important step in improving delivery of services to the HMD is to clarify the program’s goals and redefine the reporting requirements that derive from them. In addition, we suggest some changes to program activities in the areas of outreach, training, and community education and involvement.

Clarifying Program Goals. Common goals are essential for evaluating program outcomes. If state and county officials do not reach consensus about program goals, they may eventually see the HMD program judged a failure when in fact it successfully achieved a variety of disparate goals, none of which was given priority.

Common goals are also essential for designing appropriate reporting requirements, because reporting is most useful to management when it derives logically from the goals. Current requirements emphasize subsistence and mental health services provided with HMD funds. The absence of other measures—for example, engagement rates by outreach teams or obtaining and maintaining entitlement benefits for HMD clients—may suggest to provider staff that these services are not important to the program.

In thinking about revising its reporting requirements while keeping them at a minimum, the state should (1) focus the indicators on measures of outcomes related to individuals rather than on units of service, many of which may have been provided to the same individuals, and (2) clearly link the requirements to the goals of the program.

Reporting needs to be continuous—possibly monthly—rather than quarterly for a one-week period. One week is so short that it leads to broad data variations that may not accurately represent the continuing level of program activity.

Outreach. Some of the HMD not now in programs might be engaged if outreach efforts were more responsive to their routines and patterns.

Street outreach represents a relatively small proportion of most counties’ total outreach efforts, in part because street outreach is more time-consuming—and thus more expensive—than referrals or the out-stationing of workers at facilities where the HMD congregate. This raises issues of whether the more independent HMD and the more severely mentally disabled are being reached.
A related issue is outreach schedule flexibility. Many outreach programs operate only during business hours, although some have an on-call system for emergencies. Counties should be encouraged to experiment with service hours, perhaps rotating times and days to ensure access.

Agency-to-agency outreach is the most important source of referrals for many of the HMD-funded programs. This includes various mechanisms by which the agency staff who are likely to come in contact with the HMD are sensitized to the special needs of that population, made aware of the programs available to them, and trained in effective referral techniques.

In many counties physical health clinics do not appear to have been involved in the agency-to-agency referral network. Our survey showed that more than half of the HMD had visited such providers in the previous six months. We recommend including such providers in the referral networks that counties are building.

Training. Neither the state nor, generally, the counties or their contractors offer training to the HMD program staff. However, the need for training has been identified in provider meetings called by Homeless Coordinators, some of whom have moved to fill the gap by means of information-sharing or newsletters. Areas identified for training include:

- Dual diagnosed clients
- Aggressive and potentially violent clients
- Eligibility requirements and applications for entitlement benefits
- Behavioral issues (e.g., schizophrenia)
- Assessment of client needs

Community Education and Involvement. The counties' ability to serve the homeless continues to be limited by difficulties in obtaining local approval for property licensing. Indeed, the siting problem is the single most important reason why funds allocated to the counties were not fully spent in the last fiscal year. Staff reported that the counties' HMD-funded programs had a positive effect on the community at large, and that elected officials were now more aware of the homeless problem and more supportive of programs that serve this population. However, these activities have had little effect thus far in overcoming the strong community/neighborhood feelings of "yes, but not in my backyard."

There is no ready solution to this problem. Continuing public education in understanding the special problems and nature of mental
illness may help in the long run. In the meantime, comprehensive county planning efforts that emphasize community participation and equitable distribution of facilities might help to refocus the debate on the broader issues and lessen the concerns of individual communities.

ISSUES FOR FURTHER RESEARCH

This evaluation of the current HMD program raises important programmatic and organizational issues that can only be addressed by conducting further detailed research. The research should focus on four areas, each of which has potential for resolving these issues.

Allocation of HMD Funds Across Counties

In their program applications to the state, counties provided number estimates of their HMD, which were not based on thorough enumerations of the homeless populations. Consequently, to allocate the HMD funds to the counties, the State Department of Mental Health used a formula based on five factors:

- Population in households with income at or below 125 percent of poverty
- Number of disabled SSI/State Supplementary Payment recipients, excluding the blind and elderly
- Number of General Assistance recipients
- Number of unemployed
- County population

We can perform a limited test of the reasonableness of this formula by comparing the funds actually allocated with our study's estimates of the number of HMD in Alameda, Orange, and Yolo counties. The allocation of HMD funds to these counties, 4.9, 5.0, and 0.5 percent, respectively, is roughly proportional to our estimates of the number of HMD in these counties.

However, this finding does not imply that the remaining allocations would also be proportional to the number of HMD in the remaining counties. To fully test the validity of the formula, it would be necessary (1) to systematically enumerate the HMD in a larger sample of counties, using methods and definitions similar to those used in this study, and (2) to examine the correlation of the funds allocated to the sizes of the HMD populations found. We believe that the enumeration method used in this study could be used in other counties, at a reasonable cost (approximately $7,000 to $15,000 per county).
Effectiveness of Alternative Service Organizations

Our study was not designed to determine which of these or any other service delivery strategies and institutional arrangements are most effective in engaging, stabilizing, and maintaining the HMD in the community. Answering this question would require explicitly defining the desired program outcomes and following selected HMD over time in counties that vary in institutional arrangements and service delivery and in outreach and case management practices. Such studies could help us (1) assess which outreach and case management practices, or which combinations of social and mental health services, are most effective; (2) determine whether different subgroups of the mentally disabled (e.g., schizophrenics, dual diagnosed, severely depressed) respond differently to similar intervention strategies; (3) develop appropriate intervention strategies for the hard-to-reach mentally disabled; and (4) fully identify the gaps and limitations of the service approaches developed by the current HMD-funded programs.

Fluidity and Growth of Homelessness

Our study has raised some important questions about both the fluidity and the potential growth of the homeless population.

One of the striking findings from our enumeration study is that persons who become homeless at some time during a year may outnumber by something like 9 to 1 those who are continuously homeless during that year. We suspect that most of those who become homeless during that time have been homeless before. It appears that the barrier between the homeless and those at risk of homelessness is very permeable—many individuals experience repeated cycles of being "permanently housed," then homeless.

But is the total homeless population growing? We do not really know. It is possible that the number of "first-time" homeless is growing, thus leading generally to an expanding need for services.

We need studies, focused on fluidity and growth, to answer the following kinds of questions:

- Is the number of mentally disabled individuals who are becoming homeless for the first time increasing over time? And if so, what factors are driving the increase?
- Can preventive programs be designed to reduce first episodes of homelessness?
- What percentage of the HMD population is episodically homeless, and what can programs do to break this cycle?
Answering these and related questions will require complex study designs: multiple cross-sectional surveys of homeless populations over time, as well as longitudinal studies of a single group of homeless individuals.

**Family Involvement with HMD-Funded Programs**

Our study found that service providers seldom involved families in service plans. Providers noted that many HMD had no family contacts and that those who did were presumably reluctant to involve relatives. However, our survey of the homeless found that two out of three of the mentally disordered reported ongoing contact with relatives, and 30 percent reported having stayed with a friend or relative in the past month.

Families can potentially play an important role in the treatment of the HMD. For example, one approach to treating schizophrenia is to involve the family in therapy designed (1) to help them with the difficulties they face in coping with a mentally ill family member and (2) to reduce stress for the individual with schizophrenia. Further research on the family’s role should address the following questions: How can families contribute to the care provided to the HMD? How can the burden and stress of having a mentally disabled family member be alleviated for these families? How can HMD-funded programs more effectively involve family members in managing and treating their clients?
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