Review of California’s Program for the Homeless Mentally Disabled

Georges Vernez, M. Audrey Burnam, Elizabeth A. McGlynn, Sally Trude, Brian S. Mittman
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40 Years 1948-1988

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 served. 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 programs merit 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 state agency of the State of California.
SUMMARY

Since 1980, the number of homeless persons in the United States has risen sharply, and an estimated 25 to 50 percent of them are mentally ill. The homeless mentally disabled (HMD) are not excluded from subsistence services provided by private and public agencies, but their needs differ in important ways from those of other homeless persons. California's Mental Health Services Act of 1965, more commonly known as the Bronzan-Monjonnier Act, is one of the first statewide programs designed to address these needs. It has allocated $20 million annually to the state's 58 counties to support a wide range of services, from basic needs to rehabilitation. The Act emphasizes outreach to the HMD, outreach to those "at risk" of becoming HMD, and coordination of care among community service agencies.

PURPOSE AND LIMITATIONS OF THIS STUDY

In 1986, the California State Legislature mandated an independent review of the HMD programs that the counties had established with the state funds. The review was to determine the accountability of funds; describe the demographic and mental disorder characteristics of persons served; and assess the effectiveness of the program. This report describes the results of that review.

Our assessment of the HMD program has two important limitations.

- 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.
- 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 lack statistical data describing the aggregate level of activities, characteristics of clients served, and flows of client referrals.

RESEARCH STRATEGY

The authors designed a research strategy 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 severe time constraint of seven months. The strategy included:

1. A Survey of the Homeless Population to provide a count of the number of homeless and a profile of their demographics, location, presence of severe mental disorder, and service needs. The survey was conducted in Alameda, Orange, and Yolo counties.
2. Programmatic Case Studies in Alameda, Orange, and Yolo counties and the downtown Los Angeles Skid Row area to provide a detailed picture of how the HMD program had been implemented.
3. Telephone Interviews of 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.
ESTIMATING THE NUMBER OF HOMELESS PEOPLE

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 rates are much higher than the daily rates because people move in and out of the homeless population. Our results indicate that the homeless are an extremely fluid population. Only a small proportion are continuously homeless during a year.

CHARACTERISTICS OF THE HOMELESS POPULATION

About 30 percent of the homeless populations in the three California counties and in the L.A. Skid Row area have severe mental disorders—schizophrenia, bipolar affective disorder, or major depression. We estimate 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 1155 over a year;
- In Yolo County, 34 on a given night and 105 over a year.

From 54 to 93 percent of the homeless with severe mental disorders also have a history of substance abuse or dependence. Rates of substance use disorders are similarly high among homeless persons without severe mental disorders.

In a number of respects—age distribution, marital status, and history in the armed forces—the homeless with severe mental disorders 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.

There are, however, some significant differences. Although the homeless with and without mental disorders are predominantly male, the severely mentally disordered homeless are more likely to be women than are other homeless. They also have greater functional disability; are more likely to have trouble getting enough to eat and accomplishing simple tasks; perceive themselves to be in poorer health; are less likely to be married or working; and have been without steady jobs for a longer time.

A larger proportion of the homeless with severe mental disorders receive benefits and use mental health services than do the other homeless, but the severely mentally disordered are nevertheless greatly underserved. Only about one in eight received Social Security Disability Insurance (SSDI); fewer than one in four received Medi-Cal or Medicare; only about one in five had recently used outpatient services or medications for mental health or substance use problems.

Over half of the homeless mentally disordered were helped by the staff of a program or clinic in the last month, generally with basic subsistence services (shelter, food, clothing). Only 3 percent had refused services from program staff during that time.
HMD PROGRAMS IN 17 COUNTIES

Service Priorities

The HMD legislation gives the counties flexibility to tailor their programs according to their needs and preferred institutional arrangements. Consequently, the counties varied substantially in how they allocated HMD funds among the key services. Basically, the allocation depends 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.

Service Strategies

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 services to provide 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.

The counties allocated HMD funds across the three major service areas as follows:

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shelter, crisis, and transitional</td>
<td>41 percent</td>
</tr>
<tr>
<td>residential</td>
<td></td>
</tr>
<tr>
<td>Outreach and/or case management</td>
<td>32 percent</td>
</tr>
<tr>
<td>Drop-in/socialization</td>
<td>16 percent</td>
</tr>
<tr>
<td>Other</td>
<td>11 percent</td>
</tr>
</tbody>
</table>

Service Delivery

We identified three basic approaches that counties use to serve individual clients.

1. The joint outreach/case manager model combines within one individual the responsibility for engaging clients, assessing their needs, referring them to services, and ensuring they receive the services they need and want. 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 intolerable.

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 a mental health service provider. 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, each of which may provide separate outreach or case management.
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 indicate that the HMD has no relatives or will not give the information or permission to involve them.

Approaches vary with respect to the continuity of care management over time 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.

Most services are provided through contract agencies—usually large, established providers already operating in the county. 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.

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. In general, there are no formal training programs for those working with the HMD or for the Homeless Coordinators. However, counties are currently using a range of informal training activities, and some are planning more formal programs.

Across all counties, reporting requirements for both funds and services are minimal. Current requirements do not generate enough information at either the state or local level to support effective management and to assess the relative effectiveness of the various approaches to serving clients.

Implementation Progress

The counties encountered few difficulties in implementing their programs. Reliance on the existing service network and on large, experienced service providers facilitated implementation. However, services that required establishing a new facility, e.g., a drop-in center or shelter or residential facility, were often delayed because of local opposition. This problem persists. Counties are attempting to circumvent it by reducing the size of the proposed new facilities or by using existing facilities for which they do not need new permits.

SELECTED OUTCOMES

Currently, the counties' programs appear to be most effective in providing basic necessities. The programs have been less successful in moving individual HMD into entitlement and mental health treatment programs and eventually into long-term housing. Counties cite the difficulties in negotiating the entitlement program system, capacity constraints for mental health and housing, and lack of residential alternatives as the biggest stumbling blocks in these areas.

Our survey of the homeless suggests that the program is not fully meeting the needs of all HMD.

- 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 have no one to go to for help to get services.
• More than two out of three have a history of drug or alcohol abuse.
• Nearly half rate themselves to be in fair or poor health.
• About one out of eight receives Supplemental Security Income (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.

These unmet needs cannot be filled by more effective targeting on the HMD —targeting is already generally effective—or by mobilizing underutilized service capacity, as virtually all services are currently operating near or at capacity.

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

The state HMD funding has improved coordination among counties and among service providers. And the county programs have increased community awareness of the special needs of the HMD. 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.

SERVICE GAPS

Our study has identified three areas in which significant gaps remain in the amount and types of services available to the HMD.

Underserved Groups of HMD

Three subpopulations among the HMD have needs that make them particularly vulnerable to underservice.

1. A majority of the severely mentally disabled are also abusers of alcohol or drugs (they are known as dual diagnosed clients). Program staff gave five 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.
• Capacity limitations of substance abuse programs and weak institutional relationships between them and county mental health limit the access to these services by dual diagnosed HMD.
• Substance abuse may exacerbate a psychiatric disorder, making the individual more resistant to treatment.
- Neither substance abuse programs nor mental health treatment programs are currently designed to provide the special treatment needed by the dual diagnosed.
- HMD program staff indicate that they lack experience in dealing with 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.

2. A second subpopulation now not served is the small group of HMD who will not accept a managed approach to service delivery. 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 by an extension of the initial maximum period of commitment "to allow for full stabilization of the individual" prior to his/her release and by an increase in available hospital, crisis, or transitional beds. In addition, staff also noted the need to expand—or establish—a temporary conservatorship program to help individuals discharged from hospitals or transitional facilities manage their affairs while in the community.

3. A third underserved group is the mentally disabled "at risk" of homelessness—for example, those living in board-and-care homes who may be on the verge of eviction, or those living independently but vulnerable to recertification requirements for entitlement benefits. Monitoring the "at-risk" population is an important tool in breaking the cycle of homelessness, but it is difficult and expensive because it requires regular contacts with the clients and those surrounding them, whether or not there is a current problem. At present, county programs focus primarily on the currently homeless, rather than on this at-risk population.

Advanced information technology could potentially help case managers to coordinate a client's services from several different agencies and to monitor the status of those "at risk." On-line exchanges of information about clients' service needs, level of functioning, medications, social and financial resources, and living arrangements could enable case managers to track clients. These data should also inform case managers if their intervention is required, for example, if a client's financial resources were suddenly threatened. With appropriate procedures to protect privacy, counties could experiment with computer technology to evaluate its feasibility and costs and to assess its potential for distributing information in a noninvasive manner.

Gaps in Continuity of Care

Most of the severely mentally disabled require a wide range of treatment and supportive services over their entire life. County officials and service providers identified four basic reasons why the counties cannot provide individual HMD with the continuum of services they need over time.

1. Capacity constraints limit the ability of programs to link the HMD with ongoing mental health services. In general, counties have either implemented HMD programs parallel to the existing mental health system or 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 number of clients served and the level of service provided and/or among differently diagnosed groups of the mentally disabled.

2. The counties lack appropriate alternative housing arrangements. 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 self-reliance and privacy as well as more intensive support than board-and-care facilities.

3. The severely mentally ill find it difficult to obtain and maintain the entitlement benefits they need to support a permanent residence in the community. Obtaining eligibility for most of the programs is both complex and time consuming, and maintaining it requires frequent recertification. Several counties seem to have successfully 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. These approaches could be used in other counties.

4. At best, the county HMD programs provided limited continuity in case management over time 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 without at the same time addressing several complementary issues: the low pay and high attrition rate of outreach/case manager staff; that staff's limited training and experience; and the need to develop better techniques for client tracking and follow-up.

Improving Service Delivery

Perhaps the most important step in improving the delivery of services to the HMD is to clarify the program's goals and redefine the reporting requirements that derive from them.

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 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.
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 on the appropriateness of the program's funding allocation formula, the effectiveness of alternative delivery systems, the fluidity and growth of homelessness, and family involvement with HMD programs.
ACKNOWLEDGMENTS

We are indebted to the hundreds of homeless, state and county officials, and providers of services 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 (see App. I) and made useful comments and suggestions.

The study was conducted by several researchers and truly represents an interdisciplinary team effort. M. Audrey Burnam planned and directed the survey of homeless in Alameda, Orange, and Yolo counties and was responsible for the analysis presented in Sec. III. Elizabeth A. McGlynn coordinated the fieldwork for the four case studies and was responsible for writing the results for Alameda and Orange counties and for Los Angeles Skid Row. Sally Trude wrote the case study for Yolo County. Finally, McGlynn, Brian S. Mittman, and Trude conducted all telephone interviews with county officials and service providers.

Many 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 questionnaire of the homeless. Koegel also participated in the analysis reported in Sec. III, and Wells made significant contributions on all aspects of 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.

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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 greatly. The Conference of Mayors recently estimated that the homeless increased by 25 percent between 1986 and 1987 alone. 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: For many of the homeless, homelessness is not a short-term phenomenon. 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. The homeless are only half as likely to receive these benefits as the general population (Freeman and Hall, 1987).

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 ill—according to various estimates, 25 to 50 percent of the total homeless population. This large proportion of mentally ill has been attributed to a number of factors. The most frequently cited is deinstitutionalization and the complementary policy of minimizing the length of hospitalization—policies initiated in the 1960s and still in effect. However, a more important cause is probably the policy of noninstitutionalization—not placing the mentally ill in institutions unless they pose a threat to themselves or others—which reflects societal concerns for patient rights and for protection against involuntary commitment. The community-based mental health service network that was to replace the hospital as the primary means of caring for the chronically mentally ill has been characterized as underfunded, fragmented, ill-equipped to provide the continuum of services necessary to meet the needs of these people, and unable to cope with the difficulties of “managing” an unstable population (Mechanic and Alken, 1987). And like the rest of the homeless, the mentally ill have found it difficult to apply for and maintain eligibility for benefits such as Supplemental Security Income (SSI), General Assistance, Medicaid, and Medicare.

The homeless mentally disabled (HMD) are not excluded from shelters, 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, more commonly known as the Bronzan-Monjonnier Act (hereinafter called the state HMD program), is one of the first

1California State Legislature, Assembly Bill No. 2541, Chapter 1285, 1985 Regular Session, Deering’s California Codes, No. 7, 1985, pp. 103-121.
statewide programs to reflect these features. It allocated $20 million annually to the state's 58 counties to support a wide range of services, from basic needs to rehabilitation. The Act emphasized outreach to the HMD and to those "at risk" of becoming HMD, and coordination of care among community service agencies.

Several features of this 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 for the population in need. Finally, it gave counties flexibility to tailor their programs according to their respective needs and preferred institutional arrangements.

STUDY OBJECTIVES

Recognizing the novel approach and unique characteristics of this legislation, the California State Legislature required an "Independent Performance Review of County Homeless Programs Operating with the Homeless Mentally Disabled Targeted Funds." The scope of this review was to determine the accountability of funds; describe the demographic and mental disorder characteristics of persons served; and assess the effectiveness of the program.

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 emphasizing: provision of subsistence services; coordination of multi-service delivery; ability to engage clients; continuity of care; placements of clients in permanent residences, job training, and other rehabilitative programs; and assistance in obtaining institutional support such as general or veterans' assistance and medical treatment.
• 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.

ORGANIZATION OF THE REPORT

The remainder of this report is organized as follows:

Section II describes the HMD program and our methodology for addressing the objectives listed above.

Section III provides estimates of the number of homeless and discusses some demographic and psychological characteristics of both the homeless in general and the severely mentally disordered homeless in particular.
Section IV describes the services provided by the HMD program and selected outcomes of the program.

Section V summarizes the major findings, discusses some gaps in services identified in our assessment, and suggests directions for future research.
II. HMD PROGRAM DESCRIPTION AND STUDY METHODOLOGY

In this section, we describe the California HMD program and discuss our study design and methods for evaluating it.

THE HMD PROGRAM

The homeless mentally disordered have become significant burdens on local governments and charitable relief organizations whose resources are overwhelmed by the number of persons requiring emergency food and shelter. Lack of access by mentally disordered homeless persons to necessities such as shelter, food, medical care, and mental health treatment represents a threat to their health and safety. Businesses and local economies are also impacted by the presence of homeless mentally disordered persons who do not have access to these necessities (California State Legislature, 1985, p. 109).

This finding by the California State Legislature led to the creation of the “Community Support System for Homeless Mentally Disabled Persons,” Chapter 2.6 of the HMD program. Prior to this legislation, neither the state nor most counties had programs specifically targeted on 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, 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.

Intent

The goal of the HMD program is
to assure that needed community services are provided to homeless mentally disabled persons and those at risk of becoming homeless to stabilize, maintain, and enhance their living in the community (California State Legislature, 1985, p. 112).

The program was not limited to those who were literally homeless. The legislature clearly intended that mentally disabled persons who may move in and out of institutional or
family/friend living arrangements or who may be isolated in inappropriate living arrangements should also be served. The task of defining this “at-risk” population was left to the State Department of Mental Health. The legislature did not further define “mentally disabled,” but did specify that program funds were not intended to serve those persons with a primary diagnosis of substance abuse.\(^1\)

Two additional and important declarations of intent by the State Legislature should be noted. First, the legislature reemphasized the ultimate objective of community living for mentally disabled persons by stressing that the program should help them to “secure, stabilize, and maintain safe and adequate living arrangements in the community.” This objective was reinforced by making acceptance of individual services voluntary. Clients could not be forced to accept services, nor could the acceptance of one set of services (e.g., shelter) be contingent upon the receipt of other services (e.g., mental health treatment). Second, the legislature recognized that attaining this objective might be difficult and that it might require long-term support and treatment services. Thus, it stressed that funds would be made available to counties to assure the delivery of long-range services.

**Programmatic Guidelines**

The legislation encourages an individualized approach to service delivery and treatment that tailors services to the needs and unique progress of each individual. Thus, it requires that service providers develop a written individualized service plan with full participation of the client. The plan should specify the services to be provided and the expected outcomes. Service providers are to encourage clients to include family members, friends, and primary therapist or physician in service planning and implementation.

To meet each client’s individual needs, the program may fund a broad spectrum of services:

- Assistance in securing and maintaining housing, food, and clothing arrangements.
- Assistance in securing and maintaining income and health benefits.
- Assistance with money management.
- Crisis intervention services, focusing on finding appropriate alternatives to acute inpatient hospital care.
- Social and vocational skill development activities, as determined by each client’s needs, interests, and abilities.

Priority for active outreach and services is to be given to homeless mentally disabled persons not previously served by any local or state programs.

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\(^1\)In its directive to counties, the State Department of Mental Health specified that the funds were intended to provide community support services for “chronically mentally disabled adults who are homeless or at risk of becoming homeless.” According to the directive, the at-risk person:

- Is an adult suffering from a serious mental disorder; and
- Is living under circumstances inappropriate to his/her health safety and daily needs; and/or
- Has demonstrated a pattern of moving in and out of living arrangements, of isolation, and/or is unable to obtain or manage resources.

See State of California Department of Mental Health, DMH Letter No. 85-37, October 15, 1985, p. 3.
Service Delivery Guidelines

Within the general intent and programmatic guidelines outlined above, the legislation allows the counties maximum flexibility in setting service and target population priorities. The only constraint is that funds cannot be used to substitute for pre-existing federal, state, county, or private funding; they must be used either to expand existing county mental health or other social services or to provide new ones. This "maintenance of effort" is to be demonstrated in the county budget submitted to the state with the annual mental health county plan.

With respect to actual service delivery, counties have the discretion either to provide some or all of the services directly or to contract for any portion of them with public or private agencies. If counties choose to do the latter, they are to give priority to providers that have demonstrated management experience and ability or desire to work with the homeless mentally disabled.

STUDY DESIGN AND METHODS

Research Strategy

To provide the independent assessment of the HMD program requested by the State Legislature, we chose to implement a three-step research strategy.2

1. A Survey of the Homeless Population to provide a count of the number of homeless and a profile of their demographics, location, presence of severe mental disorders, and service needs. The survey was conducted in three counties.

2. Programmatic Case Studies in three counties and the Los Angeles downtown Skid Row area. (We selected Los Angeles Skid Row to take advantage of a recent detailed and reliable profile (Farr et al., 1986)3 of the homeless there; furthermore, this area has the largest concentration of homeless in the state.) The case studies provide a detailed picture of how the HMD program was implemented in these areas, including the range and types of services delivered, client characteristics, and service outcomes. One-week field visits were made to each of the selected counties. Semistructured interviews constituted the primary data-gathering procedure, supplemented by researchers' informal observations and by program documentation such as reports, statistics, and memoranda. We have used examples from the case studies to illustrate our discussion of program effects (Sec. IV) and unmet needs (Sec. V). A detailed description of the case studies results appears in App. I.

3. Telephone Interviews of 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 their views about the effects of the county programs.

This 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

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2As a preliminary step and aid to our selection of a sample of counties for study, we also developed an inventory and brief summary description of characteristics of all county programs in the State of California, based exclusively on readily available data—primarily the counties' program applications submitted to the State Department of Mental Health. This inventory appears in App. H.

3Our decision to include the Los Angeles Skid Row area was included as part of the proposal we submitted to the state.
issues, and (2) to do so under the severe time constraint of seven months. In the first two levels of the research design, we traded comprehensiveness and reliability for more detailed coverage of three counties and the Los Angeles Skid Row area. In the last level we made the opposite trade-off, emphasizing coverage of the largest possible number of counties and programs within counties, but on a more limited range of issues. Overall our aim was to learn as much as possible about how many HMD there are and who they are; what service strategies were devised to serve them and how those strategies were implemented; how outreach and other services were actually delivered; and what the effects have been.

Below we discuss briefly the key methodological components of the study.

Selection of Sites

Telephone Interviews in 17 Counties. We chose 17 counties for the telephone interview component of the study to obtain variation in:

- Population size, density, ethnic composition, and size of HMD allocation relative to total budget for mental health.
- Programmatic approaches and emphases.
- Service priorities.
- Institutional arrangements for delivery of services to the HMD.

In selecting the 17 counties, we included a priori the four counties with the largest allocation of HMD funds—Los Angeles, San Diego, San Francisco, and Orange—which represent 49 percent of the state population and 54 percent of the HMD funds allocated to counties. We used a cluster analysis to divide the remaining counties into 10 groupings with similar characteristics. Based on this analysis, we made a preliminary selection of counties, which we reviewed with representatives of the State Department of Mental Health. Our final list of 17 counties, shown in App. A, includes 75 percent of the state population and 77 percent of the HMD funds allocated to counties.

Case Study Sites. Given that we were going to use the already-completed study of Los Angeles Skid Row, we selected three other counties to obtain variation along the following dimensions: (1) rural vs. urban; (2) Northern vs. Southern California; (3) proportion of ethnic populations; and (4) programmatic variations in the type and delivery of services to the HMD, biased toward counties thought by state legislative and executive staff to have implemented innovative approaches.

The counties selected as a result were Alameda, Orange, and Yolo.

Selection of Respondents

We collected interview data to represent several types of respondents: homeless persons; county mental health officials and other officials; HMD program directors and staff actually providing the services; and other key actors involved in homeless and mental health issues. The respondents were distributed as follows:

Individual Homeless

- In shelters (121 in 3 counties)
- On the street (194 in 2 counties)

This analysis is described in App. A.

An additional 325 homeless were interviewed in Los Angeles Skid Row in 1986, sampled as they used shelter beds, meal services, or indoor congregating areas of programs serving the homeless.
County Mental Health Officials
Directors of Mental Health (17)
Homeless Coordinators (17)

Other County Officials
Police (11)
Mental Health Advisory Board members or advocates (13)

HMD Programs
Program directors (60)
Service delivery staff (85)

We selected homeless individuals on the basis of a probability sample, designed to provide a reliable estimate of the number and characteristics of the homeless in shelters and “on the street.” Shelters included all county shelters except those for battered women. “On the street” meant each street, back alley, bus/train depot, abandoned building, beach, riverbed, park, campground, and over- and underpass in selected census blocks. The details of our sampling design are described in App. E.

We included Directors of Mental Health and Homeless Coordinators in all 17 counties because they have functional responsibilities for designing, implementing, and overseeing the delivery of services to the HMD.

Within each county we also interviewed individuals, identified by the Directors of Mental Health and the Homeless Coordinators, who were directly or indirectly involved with the HMD program either as staff of county agencies other than mental health or as members of private agencies or advisory committees dealing with mental health and/or homeless issues.

In each county, we selected up to five agencies funded fully or partially with HMD funds to represent actual operational activities. We included at least one outreach program in each county because the State Legislature gave priority to this activity. We conducted a telephone interview with the director or his/her representative of each program selected.

Finally, for the case studies and field interviews and observations, we sought to interview staff who had direct contacts with the HMD population; such staff included outreach workers, case managers, intake workers, shelter directors and social service staff, and drop-in and socialization center directors and staff. Most of these staff were identified in the course of the field visits to the specific programs.

Design of Survey Instruments

We designed our various survey instruments to facilitate and standardize data collection across the levels of the research design. Each survey instrument was pretested and revised. Below, we briefly discuss each instrument.

Questionnaire for Survey of the Homeless. We used a brief screener questionnaire to determine if individuals encountered on the street were actually homeless. For a sample of homeless individuals encountered in the street or in shelters, we conducted a 20-minute interview that included questions about mental health and use of programs and services.

The homeless interviews covered the following topics:
Screener
- Residential status
- Demographic characteristics
- Length of stay in shelter
- Interviewer observations regarding homelessness, intoxication, and appearance and physical condition.

Questionnaire
- History of homelessness
- Subsistence patterns
- Type of mental illness and substance abuse, if any
- Use of mental health, physical health, and HMD services
- Experience with outreach and case management
- Ability to function (physical, social, work history)
- Family or conservator/guardian support
- Receipts of entitlements/benefits
- Interviewer observations regarding intoxication, appearance and physical condition, and rating of social skills.

A sample interview protocol appears in App. B.

Guidelines for Case Studies. Agencies—whether private or public—were the main unit of observations for the site visits. Our aim was to learn about all the relevant activities in the selected agencies.

The site visits were structured by a set of open-ended questions and observation guidelines (see App. C) covering the following topics:

- Program location, capacity, maintenance, and appearance
- Program intent, population target, indicators of program success
- Activities provided directly by the program or by someone else for the program
- Techniques used to engage the HMD, experiences in this area, and ability to get the HMD to accept services
- Ability to maintain the HMD in the program over time (continuity of care) and difficulties encountered
- Utilization of program compared with capacity
- Linkages with other private and public programs including entitlement, mental health, police, and housing programs
- Referral activities into and out of the program.

In addition to the above, another set of open-ended questions were used during the site visits to structure face-to-face interviews with staff of agencies providing social, entitlement, housing, and police services (see App. C). The questions covered the extent of their involvement with the HMD, their reliance on the HMD program to assist them and vice versa, and the difficulties they encountered serving the HMD.

Both the observation and interview guides were flexible enough to accommodate differences in local context, program variations in type and level of activities, and the perspectives of informants.

For each program, we also collected written documents, forms, and reports, including statistical reports of activities and profiles of the clientele served, screening and service plan forms, and other forms used for conducting daily work or collecting statistics.
Interview Protocol for Telephone Survey. The interview protocols administered to key county department of mental health and HMD program officials and staff in the 17 counties were semistructured and covered the following topics:

- Pre-HMD program activities and areas of underservice
- Revised estimates of homeless and HMD population size
- Goals and intended target population(s) of county program
- County strategy to serve the HMD
- Homeless Coordinator functions
- HMD service providers' characteristics
- Characteristics of population served
- Community awareness
- Ability to engage the HMD, maintain clients in service, and serve the HMD who are substance abusers
- Service gaps and needs

The interviews lasted from 45 to 75 minutes. A sample interview protocol appears in App. D. We collected data during the summer and fall of 1987.

STUDY LIMITATIONS

This 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, and none had been fully operational for more than nine months.

Thus, what we have observed are programs in transition, where the learning and adjustments characteristic of all new programs are still very much part of day-to-day activities. Even more important, the short-term level of performance we were able to measure may not represent the level of performance that may be attained in the longer term. Indeed, some respondents declined to answer questions about their program's effect either because they felt they did not have enough experience with the program, or because the HMD engaged in the program had not had enough time to progress along the continuum from receiving subsistence services to receiving mental health treatment and entitlements benefits, and eventually to being placed in some form of permanent housing.

(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.

Thus, to a significant extent, our findings reflect staff views, based on their experience with the program. Previous studies using similar methodology have found that such data are quite reliable. Nevertheless, we have been frustrated by the lack of statistical data describing aggregate level of activities, characteristics of clients served, and flows of client referrals. In part this lack reflects the newness of a program that gave highest priority to putting services in place; the program's initial reporting requirements at both the state and county levels were, and still are, minimal. The limited time and resources provided for this study did not allow us to conduct systematic statistical data collection of our own. We return to the issue of data collection again in Secs. IV and V.
III. COUNTING AND CHARACTERIZING THE HOMELESS

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?

In this section, we answer those questions based on a survey of the homeless and estimates of their numbers in three counties—Alameda, Orange, and Yolo—and another survey of homeless in the downtown Los Angeles Skid Row area. We first present our number estimates and briefly describe our estimation approach. Then we present the results of our interviews with the homeless, showing prevalence of serious mental disorders, characteristics of those with and without serious mental disorders, subsistence patterns, and use of services. In both subsections, we provide an overview, then a more detailed discussion.

ESTIMATING THE NUMBER OF HOMELESS PEOPLE

Overview

We estimate that: Alameda County has about 1,000 homeless persons on a given day and about 2,800 over 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 rates are much higher than the daily rates because people move in and out of this population. Our results indicate that the homeless are an extremely fluid population. Only a small proportion are continuously homeless during a year. People who become homeless at some time during the year represent 90, 97, and 81 percent of the total annual prevalence of homelessness in Alameda, Orange, and Yolo counties, respectively.

It is important to note that these estimates are subject to several inherent sources of bias: (1) seasonal variation in the number of homeless, (2) restrictive definition of homelessness, (3) failure to count all homeless, and (4) absence of longitudinal information. With the exception of the seasonal variation, these biases are toward underestimation. Thus, our estimates should be considered the lower bound of the actual homeless populations in these counties.

Below, we describe our estimation strategy, the estimates themselves, the various adjustments we made to arrive at those estimates, and limitations of our estimation methods.

The Estimation Strategy

In the past, the HMD estimates provided by counties have generally been “best guesses” rather than systematic estimations. Ours is the first thorough, empirically based attempt to estimate the size of the total homeless population in any California county.

Our methodology is briefly discussed in Sec. II. Appendix E describes our sampling design and App. F describes the survey’s field procedures.
Our research strategy was to:

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

People in the streets were counted if they clearly appeared to be homeless, or if they said that they had not been able to stay in a room, apartment, or home at least one night in the past month. We found it infeasible to directly count people who are usually or episodically homeless but happens to be in hospitals, jails, single-room occupancy hotels, or staying with family or friends at the time of the survey.⁴ 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. Appendix E describes our strategy for selecting areas of the counties to search for and count homeless people.

Estimating the Point Prevalence and Annual Prevalence of the Homeless

For each county, we estimated the point prevalence of homeless persons (i.e., the homeless population at one point in time); adjusted this estimate for possible bias by including the homeless who were temporarily housed on the survey night; and then estimated the annual prevalence of homelessness using our survey information. Our study could not directly count individuals over a year's time.

The point prevalence estimates include people who have been homeless for both long and short periods but exclude the previously homeless whose status has changed (for example, those who have found housing, have moved, or have died). These estimates also exclude individuals who may become homeless in the near future. Because people move in and out of the homeless population, the annual prevalence will be larger than the point prevalence of homelessness.

These results represent our best estimates of the number of homeless in the counties after weighting our counts for the sampling design, after inflating the counts to consider homeless that may have been missed, and after including in the counts a second enumeration of Alameda County areas.⁵

Point Prevalence. Table 3.1 shows our estimates of the homeless population in Alameda, Orange, and Yolo counties on a given night, based only on counts of persons who were actually homeless on that night. The estimates have not been adjusted to include

³This strategy is modeled after a recent study of Chicago by Rossi et al. (1986).
⁴The "streets" included back alleys, parks and campgrounds, vehicles, abandoned buildings, bus and train depots, all-night coffee shops and theaters, beaches, riverbeds, and along barbers.
⁵Their dispersion and proportionately small numbers led us to this conclusion.
⁶We conducted two enumerations in Alameda County because our field experience indicated that the initial survey of local experts had not been thorough enough. Both enumerations are described in detail in App. E.
homeless individuals who may have been temporarily housed at that time, but they do include the homeless in emergency shelters. On any given night in Orange County, Table 3.1 shows that we estimate as many as 764 people are homeless. For Alameda and Yolo counties the corresponding estimates are 817 and 71, respectively. Some homeless people were undoubtedly housed temporarily on the night of the survey (i.e., with friends or family, or in a hotel room, jail, or a hospital). Our estimates adjusted to account for this suggest that there are 962 homeless persons in Alameda County, 971 in Orange County, and 84 in Yolo County on any given night. The estimates in Table 3.1 are the midrange values of the high and low estimates shown in App. E. For the street population, the low estimates were based on counting individuals who were homeless, and high estimates were based on counting in addition those who were judged to be “possibly” homeless. For the shelter population, low estimates were based on a census of shelters on the nights of the survey, and high estimates were based on a typical census reported by shelter providers.

Annual Prevalence. Let us first define the terms “annual prevalence” and “annual incidence.” Annual incidence of homelessness is the estimated number of individuals who become homeless over a year. Annual prevalence of homelessness is the estimated number of individuals who are homeless at any time over a year. To estimate annual prevalence in each county, we used survey data indicating the last time a homeless respondent had a regular home for at least 30 continuous days.

Table 3.2 shows the estimated annual incidence, the estimated numbers of individuals who are continuously homeless over a year, and their sum or the estimated annual prevalence.

Table 3.1

<table>
<thead>
<tr>
<th>Location of Homeless</th>
<th>Alameda</th>
<th>Orange</th>
<th>Yolo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street</td>
<td>522</td>
<td>346</td>
<td>64</td>
</tr>
<tr>
<td>Shelter</td>
<td>295</td>
<td>418</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>817</td>
<td>764</td>
<td>71</td>
</tr>
</tbody>
</table>

6These estimates do not show the range of uncertainty due to sampling error. However, as described in App. E, sampling error could result in a substantial range of uncertainty only in the Orange County street sample and in the second enumeration of the Alameda County street sample.

7One of our survey items asked homeless individuals how many nights they had spent in temporary housing in the past month. From this we calculated the probability that a surveyed homeless individual would be temporarily housed on a given night. These numbers were added to the midrange of the county point prevalence estimates shown in Table 3.1. However, the adjustment probably underestimates the numbers of temporarily housed. We expect that those surveyed have a lower probability of being housed temporarily than those who were actually temporarily housed on the survey night.

8Annual incidence was calculated by determining the proportion of the surveyed homeless who had become homeless in the past month, multiplying this by the point prevalence of homeless persons in each county, and then multiplying by 12.

9The numbers of continuously homeless individuals were calculated by determining the proportion of surveyed homeless persons who had been continuously homeless for at least a year, and multiplying this by the point prevalence of homelessness in each county.

10The estimate of annual prevalence of homelessness rests on the assumption that the homeless population changes little in size over the course of a year. Thus, the annual remission rate is assumed to equal the annual incidence rate.
Table 3.2

ESTIMATED ANNUAL INCIDENCE AND PREVALENCE OF HOMELESSNESS

<table>
<thead>
<tr>
<th>Category</th>
<th>Alameda</th>
<th>Orange</th>
<th>Yolo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbers who become homeless during 1-year period (annual incidence)</td>
<td>2,535</td>
<td>4,294</td>
<td>131</td>
</tr>
<tr>
<td>Numbers who are continuously homeless during 1-year period</td>
<td>255</td>
<td>147</td>
<td>31</td>
</tr>
<tr>
<td>Total homeless persons during 1-year period (annual prevalence)</td>
<td>2,790</td>
<td>4,441</td>
<td>162</td>
</tr>
</tbody>
</table>

The figures indicate that homeless service providers are dealing with a highly fluid population. Only a small proportion are continuously homeless during a year. Those who become homeless represent 90, 97, and 81 percent of the total annual prevalence of homelessness in Alameda, Orange, and Yolo counties, respectively.11

Limitations of Prevalence Estimates

Seasonal Variation. Our point prevalence estimates are based on surveys conducted in September and October. If the homeless population varies greatly between summer and winter, these estimates may be inaccurate. We cannot estimate from our data whether the size of the homeless population varies seasonally, much less the magnitude of this variation.

Restrictive Definition. Our estimates use a somewhat narrow definition of “homelessness” in two ways. First, we did not focus on those at risk of becoming homeless simply because counting this population was not feasible. However, the legislation specifies that this group should also be served. 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, have not been included in our estimates. Second, we did not count people who were temporarily housed on the survey night, and, for reasons noted previously, our adjustments are likely to have underestimated their true number.

Failure to Count All Homeless. We may have failed to count all the people actually homeless at the time of the survey, for two reasons. First, we may not have found some of the homeless who were actually in the sampled blocks. However, we believe this was not a serious limitation because of the thoroughness with which the sampled blocks were searched. (For a description of our field procedure, see App. F.) Second, we did not sample and search tracts and blocks that our experts identified as having no homeless. Because there were so many of these areas in the counties, their omission may have led to substantial underestimates.12

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11 We cannot determine from our survey data the extent to which the population becoming homeless over the course of the year is composed of newly homeless persons or those who have had previous episodes of homelessness. Data from the Los Angeles Skid Row study, however, found that, of those becoming homeless within the past year, 80 percent had prior episodes of homelessness (Farr et al., 1986).

12 As a check on the reasonableness of eliminating these “zero-estimate” tracts from our sample and enumeration, we searched 17 blocks in 7 zero-estimate census tracts in Alameda County. We found one homeless person in one of these blocks, and another individual in another block who could not be positively identified as homeless. If this pattern is typical for other zero-estimate areas, omission of them from our sampling frame resulted in underestimates of 13 to 22 percent in Alameda County. We did not search any zero-estimate tracts in Orange or Yolo counties, so we cannot estimate the size of the undercoverage in these counties. We have no reason to believe that underestimation due to omission of zero-estimate areas in those counties would be any greater than in Alameda County.
Absence of Longitudinal Information. We have assumed that the size of the homeless population is fairly constant over time. However, given evidence that the homeless population has been increasing nationally, that assumption may not hold for our three counties. To account for changes in this population's absolute size, annual prevalence estimates would need to include information from multiple counts of homeless individuals over time in a given area and from survey panels using longitudinal designs. Absence of this information has probably led to underestimation.

CHARACTERISTICS OF THE HOMELESS POPULATION

Below we describe the results of our interviews with homeless persons in three counties—Alameda, Orange, and Yolo. We also present comparable data from a prior survey of homeless in the downtown Los Angeles Skid Row area. Our discussion here is basically a profile of the homeless: the prevalence of serious mental disorders, demographic characteristics, subsistence patterns, functioning, resources, and use of services. Fieldwork for this profile took place in the fall of 1987, about 18 months after counties began to implement their respective HMD programs.

Our methodology for sampling and surveying the homeless in three counties is summarized in Sec. II. Appendix E discusses our sampling plan in detail. A comprehensive description of the survey field procedures is provided in App. F. To make our survey results generalizable to all the homeless in each county, we have weighted the data to adjust for the differential probability of selection. The weights are presented in App. E. The methodology for sampling and surveying the homeless in the downtown Los Angeles Skid Row area is described in detail by Burnam and Kogel (forthcoming). This latter survey was designed to provide a self-weighting representative sample of the entire homeless population in the Los Angeles Skid Row area. The survey should not, therefore, be taken to represent the homeless population of the entire County of Los Angeles.

Overview

About 30 percent of the homeless populations in the three California counties and in the Los Angeles Skid Row area have severe mental disorders—schizophrenia, bipolar affective disorder, or major depression. We estimate 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.

The majority (from 54 to 93 percent) of the homeless with severe mental disorders also have a history of substance abuse or dependence and are dual diagnosed (with both mental and substance use disorders). Rates of substance use disorders are similarly high among homeless persons without severe mental disorders.

In a number of respects—age distribution, marital status, and history in the armed forces—the homeless with severe mental disorders 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.
Not surprisingly, the homeless with severe mental disorders have greater functional disability than other homeless. They are more likely to have trouble getting enough to eat and accomplishing simple tasks. They perceive themselves to be in poorer health. They are less likely to be married or working, and have been without steady jobs for a longer time. And although the homeless with and without mental disorders are predominantly male, the severely mentally disordered homeless are more likely to be women than are other homeless.

Overall, the homeless receive few benefits or entitlements and use mental health services infrequently. A larger proportion of the homeless with severe mental disorders receive benefits and use mental health services than do the other homeless, but the severely mentally disordered are nevertheless greatly underserved. Only one in ten was receiving SSI or Social Security Disability Insurance (SSDI); fewer than one in four was enrolled in Medi-Cal or Medicare; only one in three had recently used outpatient services or medications for mental health or substance use problems.

Over half of the homeless mentally disordered were helped by the staff of a program or clinic in the last month, generally with basic subsistence services (shelter, food, clothing). Only 3 percent of the homeless mentally disordered refused services from program staff in the last month.

Severe Mental Disorders

Defining Mental Disability. 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.

In developing an operational definition of severe mental disorder, we followed several principles. (1) We relied on the definitions of psychiatric disorders in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980), hereinafter known as DSM-III. (2) We excluded substance use disorders from our definition of severe mental disorder because the HMD legislation specifically excludes funding services for persons with a primary diagnosis of substance abuse. (3) We decided to focus on disorders that can cause psychotic symptoms and are likely to be either chronic or recurrent or cause longstanding residual symptoms. This focus seemed the most consistent with the intent of the legislation and with prior research definitions.

The disorders we included are major affective disorders (recurrent major depression or bipolar disorder) and schizophrenia. We did not include organic disorders because no standardized measures of specific organic disorders are suitable for use in survey research, and information on general cognitive functioning is difficult to interpret without information from a comprehensive medical workup for organic pathology. We did not select personality disorders, such as borderline or antisocial personality, or anxiety disorders because these are not commonly associated with psychotic symptoms.

Although we excluded primary substance abuse from our definition of mental disorder, we decided to separately identify and describe homeless persons with substance use disorders (whether 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. Second, substance abuse is highly prevalent among the homeless (Koegel and Burnam, 1987; Fischer et al., 1986) and is associated with disability (Wells, Golding, and Burnam, forthcoming). We thought, therefore, that the
problems of substance abuse had particular policy relevance for programs designed for the homeless mentally disabled.

**Developing a Screening Questionnaire.** To determine if our respondents had one of the three severe mental disorders mentioned above, 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 DSM-III criteria. The instrument displays adequate reliability and validity for research purposes and has been used in several large-scale population studies sponsored by the National Institute of Mental Health. The DIS was too long (about an hour) for our respondents—especially because they were going to be interviewed in the dead of night—so we selected key DIS items that were likely to be highly predictive of the diagnoses obtained when using the full DIS. We tested the ability of the screener questions to detect individuals with the full DIS/DSM-III diagnosis by using survey data from the Los Angeles Skid Row study (in which the DIS had been administered). We found that the final screener instrument, which consisted of 24 items and took approximately 10 minutes to administer, was highly predictive of disorders that were assessed using the full DIS. These results are shown in App. G.

Across the three counties, a total of 315 homeless adults completed the face-to-face interviews. About 38 percent of the interviews were completed with persons who were in shelters; the remaining interviews were conducted as part of the “street” sample. Acceptance rates for the survey were high. For those in shelters, the average rate was 89 percent; for the street sample, the average was 78 percent. These high rates give us confidence that our findings cannot be seriously biased by nonresponse. Details of sample sizes and response rates by county can be found in App. F.

**Prevalence of Mental Disorders.** Table 3.3 shows the estimated percentage of homeless persons in each of the three counties and Los Angeles Skid Row with specific mental and substance use disorders. The prevalence of persons with any severe mental disorder in these counties ranges from 26 to 40 percent. Prevalence do not vary substantially across the three counties and Los Angeles Skid Row in spite of dramatic variations across these areas in urbanization, population density, socioeconomic and demographic characteristics, and mental health and social service delivery systems. Prevalence of lifetime substance abuse ranges from 55 to 87 percent, and the percentage with dual diagnoses ranges from 14 to 37 percent. Those with dual diagnoses represent 54, 55, and 93 percent of the mentally disabled in Orange, Alameda, and Yolo, respectively, and 71 percent in Los Angeles Skid Row. Among other homeless, history of substance abuse is similarly high: 55, 82, and 87 percent in Orange, Alameda, and Yolo, respectively, and 69 percent in Los Angeles Skid Row.

**Demographic Characteristics**

The demographic characteristics of the homeless are shown in Table 3.4 for those who did and did not screen positive for a severe mental disorder (SMD). (In this table and elsewhere, we present data separately for the mentally disordered and the other homeless. We note differences between the two groups only when the differences reach acceptable levels of statistical significance, p < .05.) For the sake of convenience, we refer to those who screened positive for

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13These estimates are corrected for the likelihood of the screener to misclassify. The percentages of the homeless population screened positive for these mental disorders are shown in App. G.
Table 3.3
PREVALENCE OF DSM-III MENTAL AND SUBSTANCE USE DISORDERS AMONG HOMELESS
(In weighted percent)

<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>

NOTE: Estimates in the three counties are based on the assumption that false negative and false positive error rates made by the screener are the same in these homeless populations as those found in the Los Angeles Skid Row homeless population. Screener error rates may have varied across homeless populations, but the extent to which such variation occurred cannot be determined from this study.

disorder as the severely mentally disordered, but more precisely, they are a group of individuals who have a high probability of having severe mental disorder.\(^{14}\)

The homeless in each of the three counties and in Los Angeles Skid Row were predominantly male. In Orange County, which had the highest proportion of women, the women were more likely than the men to have screened positive for severe mental disorder, and this sex difference is significant when data from all three counties are combined. The homeless were widely distributed across age cohorts, but tended to cluster among the younger ages (under 45). The presence or absence of severe mental disorder is not associated with any particular age group.

Race/ethnic concentration of the homeless varies substantially across the counties, in part reflecting the demographic characteristics of the general populations: Yolo has the largest proportion of whites, Alameda and Los Angeles Skid Row have the largest proportion of blacks. However, there is no evidence that mental disorder varies markedly by racial or ethnic background among these homeless, with the exception of slightly higher rates of severe mental disorder among blacks relative to whites when the three county samples are combined. A high proportion of the homeless, irrespective of signs of severe mental disorder or the county in which they were found, were either divorced, separated, or never married. The

\(^{14}\) The percentages of homeless estimated to be screener positive for mental and substance use disorders are shown in App. G for the three counties and Los Angeles Skid Row. For the substance use disorders, the percentage of persons screened positive and the percentage estimated to be truly positive are very similar. For severe mental disorder, the proportion who were positive on the screener is substantially higher than the estimated prevalence of true mental disorder. Among those who were screened positive for severe mental disorder, however, the probability of actually having a severe mental disorder is very high—about 62 percent of those screened positive are expected to have severe mental disorder.

The homeless SMD referred to in the remainder of Sec. III are as defined under "Severe Mental Disorders." Elsewhere in this report we use the term homeless mentally disabled (HMD) to refer to the SMD and other subgroups of individuals with chronic mental disability as generically used by the county departments of mental health and other service providers.
Table 3.4
DEMOGRAPHIC CHARACTERISTICS OF THE HOMELESS
(In weighted percent)

<table>
<thead>
<tr>
<th>Demographic Characteristics</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></td>
<td>SMD Other</td>
<td>SMD Other</td>
<td>SMD Other</td>
<td>SMD Other</td>
<td>SMD Other</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>35</td>
<td>22</td>
<td>21</td>
<td>14</td>
<td>62</td>
</tr>
<tr>
<td>Male</td>
<td>62</td>
<td>78</td>
<td>79</td>
<td>86</td>
<td>36</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>22</td>
<td>27</td>
<td>19</td>
<td>27</td>
<td>26</td>
</tr>
<tr>
<td>25-34</td>
<td>37</td>
<td>36</td>
<td>40</td>
<td>33</td>
<td>38</td>
</tr>
<tr>
<td>35-44</td>
<td>28</td>
<td>23</td>
<td>31</td>
<td>26</td>
<td>25</td>
</tr>
<tr>
<td>45-54</td>
<td>9</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>55+</td>
<td>4</td>
<td>7</td>
<td>3</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>White</td>
<td>47</td>
<td>56</td>
<td>56</td>
<td>47</td>
<td>56</td>
</tr>
<tr>
<td>Black</td>
<td>34</td>
<td>27</td>
<td>49</td>
<td>40</td>
<td>21</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>11</td>
<td>10</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>13</td>
<td>24</td>
<td>6</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>Widowed</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Separated</td>
<td>14</td>
<td>12</td>
<td>17</td>
<td>16</td>
<td>12</td>
</tr>
<tr>
<td>Divorced</td>
<td>25</td>
<td>12</td>
<td>22</td>
<td>9</td>
<td>23</td>
</tr>
<tr>
<td>Never married</td>
<td>46</td>
<td>50</td>
<td>52</td>
<td>64</td>
<td>41</td>
</tr>
<tr>
<td>Veteran</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, Vietnam</td>
<td>10</td>
<td>10</td>
<td>13</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Yes, other</td>
<td>11</td>
<td>13</td>
<td>14</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>79</td>
<td>77</td>
<td>75</td>
<td>74</td>
<td>82</td>
</tr>
</tbody>
</table>

severely mentally disordered, however, were more likely to be divorced and less likely to be married than were other homeless persons.

About 20 percent of the homeless across the three counties and 40 percent of those in Los Angeles Skid Row had been in the armed services.

Table 3.5 summarizes the circumstances of the homeless. The proportion of those in emergency shelters on a given night varied across counties, with a relatively lower proportion found in Yolo. In Alameda and Orange, the homeless with mental disorders were more likely than other homeless to have been in shelters than on the streets when surveyed. Because these findings are weighted to adjust for probability of sampling, they suggest that the mentally disordered in these counties are more likely to receive emergency shelter than other homeless.

A small proportion of the homeless, irrespective of severe mental disorder, were currently with their spouses or with children. Orange County has the largest proportion of homeless with families, perhaps because its campground offers a relatively safe environment and/or because low-cost housing is a greater problem in this area.
Table 3.5
CURRENT CIRCUMSTANCES OF THE HOMELESS
(In weighted percent)

<table>
<thead>
<tr>
<th>Circumstances</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></td>
<td>SMD Other</td>
<td>SMD Other</td>
<td>SMD Other</td>
<td>SMD Other</td>
<td>SMD Other</td>
</tr>
<tr>
<td>Location at interview&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelter</td>
<td>51 31</td>
<td>42 31</td>
<td>70 30</td>
<td>6 23</td>
<td>54 59</td>
</tr>
<tr>
<td>Street</td>
<td>49 69</td>
<td>58 68</td>
<td>31 69</td>
<td>94 77</td>
<td>46 41</td>
</tr>
<tr>
<td>With spouses&lt;sup&gt;b&lt;/sup&gt;</td>
<td>12 22</td>
<td>5 1</td>
<td>21 37</td>
<td>9 6</td>
<td></td>
</tr>
<tr>
<td>With children&lt;sup&gt;b&lt;/sup&gt;</td>
<td>27 23</td>
<td>11 7</td>
<td>49 35</td>
<td>0 0</td>
<td></td>
</tr>
<tr>
<td>Currently working or in school or housewife&lt;sup&gt;c&lt;/sup&gt;</td>
<td>15 31</td>
<td>8 8</td>
<td>27 49</td>
<td>38 5</td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup>For L.A. Skid Row homeless, the street sample consisted of persons interviewed while in meal lines or drop-in centers, who had not slept in a shelter in the past month. The shelter sample in the L.A. Skid Row study included persons in shelters and those staying in voucherized hotel rooms.

<sup>b</sup>This information not available for L.A. Skid Row study.

<sup>c</sup>For L.A. Skid Row study this shows percentages currently working for pay.

Approximately 3 to 9 percent of the homeless sample in Yolo, Alameda, or Los Angeles Skid Row were currently working (working for pay, going to school full-time, or working as a housewife). In Orange County, however, almost half of the non-SMD and about 25 percent of the SMD are currently working.

Subsistence Patterns

Table 3.6 shows where the homeless get their food and where they sleep.

The most common food sources were missions, shelters, or soup lines; markets or restaurants were slightly less common sources. Yolo County has a larger proportion of homeless, with and without severe mental disorder, who most often find their food on the streets. When homeless individuals were asked how much of a problem it was to get enough to eat in the past month, the severely mentally disordered in all three counties and Los Angeles Skid Row tended to report more of a problem than did other homeless. Problems getting enough to eat were most striking among the severely mentally disordered in Yolo and Alameda counties, where 37 and 18 percent, respectively, said they usually had a problem getting enough to eat.

The homeless in all three counties and in Los Angeles Skid Row most often slept either in shelters or outside. In Alameda and Orange, the severely mentally disordered were more likely than other homeless to have slept in a shelter in the past month, consistent with the fact that the severely mentally disordered were more likely than other homeless to have been in shelters on the night of the survey.

The fact that the subsistence patterns of the SMD do not vary dramatically from those of other homeless individuals does not imply that the basic needs of those with mental disorders are well provided for. Indeed, almost 40 percent of the mentally disordered in the combined
Table 3.6

SUBSISTENCE PATTERNS OF THE HOMELESS
(In weighted percent)

<table>
<thead>
<tr>
<th>Subsistence Characteristics</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></td>
<td>SMD</td>
<td>Other</td>
<td>SMD</td>
<td>Other</td>
<td>SMD</td>
</tr>
<tr>
<td>In past month, where meals were most often found: Market</td>
<td>12</td>
<td>25</td>
<td>5</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td>Restaurant</td>
<td>13</td>
<td>21</td>
<td>10</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td>Shelter/soup line/mission</td>
<td>52</td>
<td>43</td>
<td>61</td>
<td>57</td>
<td>45</td>
</tr>
<tr>
<td>Friends/relatives</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Handout</td>
<td>6</td>
<td>2</td>
<td>12</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Street</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Institution</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>In past month, getting enough to eat was a problem: Usually</td>
<td>13</td>
<td>5</td>
<td>18</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>25</td>
<td>30</td>
<td>35</td>
<td>32</td>
<td>16</td>
</tr>
<tr>
<td>Rarely</td>
<td>20</td>
<td>8</td>
<td>19</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Never</td>
<td>50</td>
<td>56</td>
<td>27</td>
<td>57</td>
<td>58</td>
</tr>
<tr>
<td>In past month, has slept in: Relative/friend's home</td>
<td>29</td>
<td>27</td>
<td>25</td>
<td>22</td>
<td>36</td>
</tr>
<tr>
<td>Rented room</td>
<td>31</td>
<td>37</td>
<td>27</td>
<td>27</td>
<td>37</td>
</tr>
<tr>
<td>Shelter/mission</td>
<td>64</td>
<td>48</td>
<td>58</td>
<td>45</td>
<td>80</td>
</tr>
<tr>
<td>Jail</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Vehicle</td>
<td>23</td>
<td>16</td>
<td>19</td>
<td>23</td>
<td>26</td>
</tr>
<tr>
<td>Outstanding/abandoned building</td>
<td>62</td>
<td>71</td>
<td>78</td>
<td>75</td>
<td>39</td>
</tr>
<tr>
<td>Public facility</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Hospital</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Own home</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

*In the L.A. Skid Row study, this item includes both jail and other institutions.

bNot asked in the L.A. Skid Row study.

Three counties and 55 percent in Los Angeles Skid Row reported that they usually or sometimes had problems getting enough to eat in the past month.

Ability to Function

The survey included a few key indicators of functioning to suggest how much disability the homeless experienced. The indicators used were general health perceptions (a global indicator of physical and mental health commonly utilized in national population surveys), basic instrumental skills, and previous work history. The results are shown in Table 3.7.

In response to a question about whether their health was excellent, good, fair, or poor, the mentally disabled described themselves as having generally poorer health than did the other homeless. In Alameda, Orange, and the combined three counties, this difference is statistically significant.
Table 3.7
FUNCTIONING OF THE HOMELESS
(In weighted percent)

<table>
<thead>
<tr>
<th>Function Category</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></td>
<td>SMD  Other</td>
<td>SMD  Other</td>
<td>SMD  Other</td>
<td>SMD  Other</td>
<td>SMD  Other</td>
</tr>
<tr>
<td>General health perception</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent</td>
<td>18  18</td>
<td>19  21</td>
<td>20  15</td>
<td>15  31</td>
<td>19  24</td>
</tr>
<tr>
<td>Good</td>
<td>33  52</td>
<td>36  47</td>
<td>31  56</td>
<td>26  23</td>
<td>30  31</td>
</tr>
<tr>
<td>Fair</td>
<td>38  28</td>
<td>33  32</td>
<td>35  28</td>
<td>25  39</td>
<td>36  36</td>
</tr>
<tr>
<td>Poor</td>
<td>15  3</td>
<td>13  0</td>
<td>16  4</td>
<td>35  8</td>
<td>15  9</td>
</tr>
<tr>
<td>Instrumental skills, e.g.,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>need help to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buy bus ticket</td>
<td>9   6</td>
<td>6   10</td>
<td>12  3</td>
<td>17  15</td>
<td>—</td>
</tr>
<tr>
<td>Get help at ER</td>
<td>12  7</td>
<td>8   9</td>
<td>17  6</td>
<td>6   8</td>
<td>—</td>
</tr>
<tr>
<td>Find phone number</td>
<td>5   2</td>
<td>7   4</td>
<td>4   0</td>
<td>3   0</td>
<td>—</td>
</tr>
<tr>
<td>Take medication</td>
<td>3   2</td>
<td>7   2</td>
<td>3   2</td>
<td>3   8</td>
<td>—</td>
</tr>
<tr>
<td>Fill out application</td>
<td>13  6</td>
<td>18  10</td>
<td>7   6</td>
<td>21  8</td>
<td>—</td>
</tr>
<tr>
<td>Any one of the above</td>
<td>27  18</td>
<td>26  22</td>
<td>27  18</td>
<td>41  23</td>
<td>—</td>
</tr>
<tr>
<td>Held job for at least 6 months*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently</td>
<td>2   12</td>
<td>4   6</td>
<td>0   17</td>
<td>3   0</td>
<td>—</td>
</tr>
<tr>
<td>In the past</td>
<td>50  80</td>
<td>75  89</td>
<td>83  74</td>
<td>91  100</td>
<td>—</td>
</tr>
<tr>
<td>Never</td>
<td>19  7</td>
<td>22  5</td>
<td>17  9</td>
<td>6   0</td>
<td>—</td>
</tr>
<tr>
<td>Level of last 6-month job*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sheltered work</td>
<td>0   0</td>
<td>1   0</td>
<td>0   0</td>
<td>0   0</td>
<td>—</td>
</tr>
<tr>
<td>Unskilled laborer</td>
<td>18  27</td>
<td>21  32</td>
<td>10  21</td>
<td>38  31</td>
<td>—</td>
</tr>
<tr>
<td>Semi-skilled laborer</td>
<td>55  52</td>
<td>50  51</td>
<td>63  52</td>
<td>50  54</td>
<td>—</td>
</tr>
<tr>
<td>Skilled laborer/low-level</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>management</td>
<td>21  20</td>
<td>24  18</td>
<td>18  27</td>
<td>11  8</td>
<td>—</td>
</tr>
<tr>
<td>Mid-level management/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>lesser professional</td>
<td>6   1</td>
<td>4   2</td>
<td>10  0</td>
<td>0   8</td>
<td>—</td>
</tr>
<tr>
<td>Top-level management/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>major professional</td>
<td>0   0</td>
<td>0   0</td>
<td>0   0</td>
<td>0   0</td>
<td>—</td>
</tr>
</tbody>
</table>

*Not included in L.A. Skid Row study.

To assess instrumental skills, the interview asked whether the respondent could perform a variety of tasks without assistance. The tasks included buying a bus ticket, getting help at an emergency room, finding a phone number, taking medications as prescribed by the doctor, and filling out applications for benefits. Of the severely mentally disordered, 26 to 41 percent said that they needed help with at least one of these tasks; among the other homeless, 15 to 23 percent said that they needed help. In the combined three-county sample, the mentally disordered were significantly more likely to report needing help with each of the tasks. Filling out an application for benefits, getting help at an emergency room, and buying a bus ticket were the tasks most often mentioned.

Work history, particularly for men, is a crude indicator of ability to assume the role of a wage earner. The survey included a question about the last time the respondent held the same job for at least six months. If the individual had held one, it was classified according to the
level of skill and education required. Although only about 0 to 17 percent of the homeless were currently working at a job that they had held for at least six months, about 80 percent had previously held such a job. But the severely mentally disordered in Alameda and Orange were less likely to be currently holding a steady job and more likely to have never held one. Among the mentally disordered who had previously held a steady job, the average time elapsed since they had the job was 54, 35, and 52 months in Alameda, Orange, and Yolo, respectively. The other homeless had spent less time without a steady job—an average of 45 months in Alameda, 21 months in Orange, and 36 months in Yolo.

The skill level required in the last steady job held by a homeless individual was most often that of a semi-skilled laborer. Only a few persons had held jobs at management or professional levels. Overall, the mentally disordered had worked at higher-skilled jobs than other homeless, perhaps evidence of the toll that their illness has taken on previous levels of functioning. Almost none of the severely mentally disordered had worked in a sheltered work environment—a highly supervised work setting specifically designed for the mentally disabled.

As we would expect, then, functioning among the SMD is seriously limited and more limited than that of other homeless, at least in the areas assessed by our survey. However, many other homeless also have problems performing simple tasks of daily life.

## Resources and Use of Services

To develop a picture of the service needs of the HMD, the survey inquired about benefits and entitlements received, family contact and legal caretakers, use of health services, and assistance in getting access to wealth and health services.

**Resources.** Table 3.8 shows the percentage of those with and without severe mental disorder who receive benefits. With the exception of social security other than SSI or SSDI, the SMD tended to receive benefits in higher proportions than the other homeless. The differences were significant in the combined three-county sample and in the Alameda and Orange County samples. But only 7 to 18 percent of the SMD received SSI or SSDI and only 9 to 23 percent had Medi-Cal or Medicare coverage. Except for Yolo, where nearly half the SMD receive food stamps and welfare, only 6 to 26 percent of the SMD obtain these benefits.

<table>
<thead>
<tr>
<th>Benefits</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></td>
<td>SMD</td>
<td>Other</td>
<td>SMD</td>
<td>Other</td>
<td>SMD</td>
</tr>
<tr>
<td>SSI/SSDI</td>
<td>12</td>
<td>4</td>
<td>15</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Social security</td>
<td>5</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>VA</td>
<td>3</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Food stamps*</td>
<td>22</td>
<td>14</td>
<td>15</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td>Welfare</td>
<td>25</td>
<td>12</td>
<td>26</td>
<td>8</td>
<td>21</td>
</tr>
<tr>
<td>Medi-Cal/Medicare</td>
<td>22</td>
<td>9</td>
<td>22</td>
<td>12</td>
<td>23</td>
</tr>
</tbody>
</table>

*Not included in the L.A. Skid Row study.
Approximately 60 percent of homeless, irrespective of whether they have severe mental disorders, reported some type of contact with relatives in the last month. We could not determine how supportive these family relationships were. As seen in Table 3.6, 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 a substantial degree of ongoing support may be provided by relatives.

More frequently than other homeless, the severely mentally disordered said they had a conservator or guardian, but the percentage across the three counties is still low—15 percent.

Use of Health Services. Table 3.9 shows the percentage of the homeless who use mental and physical health services.

As might be expected, the severely mentally disordered were more likely to report both inpatient and outpatient visits for mental health problems in the past 12 and 6 months, respectively. Fourteen to 47 percent of the severely mentally disordered in the three counties and Los Angeles Skid Row had been hospitalized at some point in their lives, although recent hospitalization rates were much lower—from 0 to 11 percent. Fewer than one-fourth of those with a mental disorder in any area had received any mental health outpatient treatment in the past six months, and only 4 to 15 percent reported taking prescribed medications for emotional or mental problems. The mentally disordered in Yolo County were less likely than those in Alameda or Orange to have a history of mental health hospitalization or medications use.

More than half of the severely mentally disordered in all three counties reported a visit to a physical health clinic in the past six months; among the other homeless, only about one-third reported such visits. In Los Angeles Skid Row, the proportion for both groups was about 45 percent.

Table 3.9

USE OF MENTAL AND PHYSICAL HEALTH SERVICES BY THE HOMELESS
(In weighted percent)

<table>
<thead>
<tr>
<th>Health Services</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></td>
<td>SMD Other</td>
<td>SMD Other</td>
<td>SMD Other</td>
<td>SMD Other</td>
<td>SMD Other</td>
</tr>
<tr>
<td>Mental health visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever inpatient</td>
<td>28</td>
<td>7</td>
<td>36</td>
<td>10</td>
<td>21</td>
</tr>
<tr>
<td>Inpatient in past 12 mo.</td>
<td>7</td>
<td>1</td>
<td>11</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Outpatient in past 6 mo.</td>
<td>20</td>
<td>4</td>
<td>19</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>Mental health medications in past 6 mo.</td>
<td>15</td>
<td>3</td>
<td>15</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Substance use visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever inpatient</td>
<td>37</td>
<td>21</td>
<td>45</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>Inpatient in past 12 mo.</td>
<td>14</td>
<td>4</td>
<td>15</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>Outpatient in past 6 mo.</td>
<td>18</td>
<td>4</td>
<td>24</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Physical health visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient in past 6 mo.</td>
<td>55</td>
<td>31</td>
<td>52</td>
<td>34</td>
<td>57</td>
</tr>
</tbody>
</table>

aIn L.A. Skid Row study, includes hospitalisations for mental health and substance abuse reasons.
bNot included in L.A. Skid Row study.
The mentally disordered also more frequently reported visits for substance abuse than did other homeless, even though rates of lifetime substance abuse among the two groups were similar.

Assistance with Access to Services. Because the HMD legislation emphasizes outreach and case management, we wanted to assess the extent to which county programs were reaching the homeless through these activities. We asked the homeless about outreach and case management in terms of experiences that they would recognize. For example, a set of items developed to assess outreach activities asked whether, in the past month, someone from a program or clinic helped the respondent in money management, to get basic subsistence services, to get physical or mental health care, or to apply for benefits.

The results of these queries are shown in Table 3.10. 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). But the severely mentally disordered got help more often. 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 when they needed help with finding a place to sleep or getting to a health clinic or somewhere else they needed to go. In general, the severely mentally disordered are slightly more likely than the other homeless (53 versus 48 percent) to have someone to ask for assistance, but only in Orange County is there a significant difference between the two groups. However, the majority of both groups name relative or friend—not program staff—as the person on whom they rely most often.

Table 3.10

ASSISTANCE WITH ACCESS TO SERVICES AMONG THE HOMELESS
(In weighted percent)

<table>
<thead>
<tr>
<th>Service Assistance*</th>
<th>Across All 3 Counties</th>
<th>Alameda</th>
<th>Orange</th>
<th>Yolo</th>
</tr>
</thead>
<tbody>
<tr>
<td>In past month, did program staff help with:</td>
<td>SMD Other</td>
<td>SMD Other</td>
<td>SMD Other</td>
<td>SMD Other</td>
</tr>
<tr>
<td>Shelter/food/clothing/cleanup</td>
<td>45 22</td>
<td>44 33</td>
<td>55 32</td>
<td>35 31</td>
</tr>
<tr>
<td>Getting physical/mental health care</td>
<td>10 2</td>
<td>10 1</td>
<td>10 2</td>
<td>14 0</td>
</tr>
<tr>
<td>Applying for benefits/entitlements</td>
<td>13 4</td>
<td>15 8</td>
<td>8 0</td>
<td>22 15</td>
</tr>
<tr>
<td>Managing money</td>
<td>8 1</td>
<td>9 0</td>
<td>7 3</td>
<td>0 0</td>
</tr>
<tr>
<td>Something else</td>
<td>14 7</td>
<td>10 7</td>
<td>19 7</td>
<td>18 23</td>
</tr>
<tr>
<td>In past month, received no help from program staff</td>
<td>44 65</td>
<td>45 61</td>
<td>43 68</td>
<td>39 89</td>
</tr>
<tr>
<td>Help was offered but not accepted</td>
<td>3 4</td>
<td>2 5</td>
<td>2 3</td>
<td>11 15</td>
</tr>
<tr>
<td>Help was not offered</td>
<td>41 61</td>
<td>43 56</td>
<td>41 65</td>
<td>23 54</td>
</tr>
<tr>
<td>Someone is there to help in obtaining services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>47 52</td>
<td>57 48</td>
<td>35 56</td>
<td>46 29</td>
</tr>
<tr>
<td>Yes</td>
<td>53 48</td>
<td>43 52</td>
<td>65 44</td>
<td>55 62</td>
</tr>
<tr>
<td>Program staff</td>
<td>7 2</td>
<td>10 3</td>
<td>3 1</td>
<td>6 23</td>
</tr>
<tr>
<td>Legal conservator/guardian</td>
<td>0 0</td>
<td>0 0</td>
<td>0 0</td>
<td>0 0</td>
</tr>
<tr>
<td>Relative/friend</td>
<td>42 35</td>
<td>30 42</td>
<td>59 50</td>
<td>45 51</td>
</tr>
<tr>
<td>Someone else</td>
<td>4 11</td>
<td>3 8</td>
<td>5 13</td>
<td>3 8</td>
</tr>
</tbody>
</table>

*Not included in the L.A. Skid Row study.
IV. THE HMD PROGRAM IN 17 COUNTIES

One unique feature of the HMD legislation is the flexibility it gives to the counties to tailor their programs according to their needs and preferred institutional arrangements. In this section, we draw on our telephone survey of 17 counties and our case studies to describe how the counties set service priorities, organized the delivery of services, and implemented their programs.¹ We then consider selected outcomes of those programs, including service use, ability to target and engage the HMD, and coordination among services and agencies. Because the HMD legislation emphasizes outreach, we pay particular attention to the level and type of outreach implemented by the counties. Finally, we consider how each county's program has affected the community and other service agencies, and the service gaps identified by our respondents.

SERVICE PRIORITIES

Overview

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. One exception is temporary housing in shelters and motels. About one-third of the beds now available to HMD existed before the HMD program, and these are now available to the HMD on a “preferential” basis.

Service Strategies

The counties implemented one of two major service strategies:

(1) 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.

(2) Smaller counties generally chose to emphasize one service area, relying on existing services (sometimes through the use of vouchers) to provide a continuum of services. Most of these counties—illustrated by Fresno, Butte, and Yolo—focused their efforts on outreach and case management, seeking to facilitate access of the HMD to existing social and mental health services. Outreach primarily involves engaging the HMD either on the street or at service facilities and encouraging them to seek the assistance they need. Case management involves “orchestrating” service delivery from various providers to help the HMD obtain subsistence, shelter, entitlements, housing, and/or mental and physical health services. A smaller number of

¹Appendix C contains the guidelines for the case studies; App. D lists the questions asked in the telephone interviews; and App. I contains the detailed descriptions of our case studies in Alameda, Orange, and Yolo counties and Los Angeles Skid Row.
counties—illustrated by Ventura and Sonoma—made a different choice, focusing funds on shelter and housing for the HMD. 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.

Allocation of Funds

Table 4.1 shows the distribution of HMD funds by county and by major service area for the 17 counties surveyed. Only 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 4.1 shows the allocation of HMD funds across the three major service areas. The proportions in this figure and in Table 4.1 are estimates because agencies may provide more than one service, e.g., shelter and case management. We allocated all of an agency's funds to the primary service provided.

Generally, the service priorities set by the counties depended on the size of the funding allocation made to them. Six of the eight most populated counties in the state, which received about $600,000 or more in HMD funding, allocated from 39 to 63 percent of their resources to shelter, crisis, and transitional residential facilities. All but three of these large counties allocated 27 percent or more to outreach/case management services. San Francisco placed relatively greater emphasis on drop-in/socialization services, and Alameda on advocacy and mobile crisis services.

Smaller counties tended to allocate few or no funds to residential services; instead, they emphasized outreach and case management. For example, Yolo allocated 71 percent of its funds to outreach efforts, the core of its program. Among the nine smaller counties surveyed, three are exceptions to this pattern. Sonoma and Mendocino spent more than half of their allocation on residential services. And Ventura allocated all of its resources to transitional residential services.

Overall more than 800 beds have become available to the HMD in the 17 counties surveyed (see Table 4.2). 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.

Nearly all agencies reported that the services provided with HMD funds are new or net additions to services that existed previously. Our observations generally support this assessment, particularly for outreach, case management, drop-in/socialization services, and residential facilities, with one significant exception. About two-thirds of the beds in shelters now available to HMD existed before the HMD program. Most are located in shelters that continue to serve other homeless. HMD funding, however, assures the HMD priority access to these beds.
### Table 4.1

**ESTIMATED DISTRIBUTION OF HMD FUNDS BY COUNTY AND MAJOR SERVICE CATEGORY**

<table>
<thead>
<tr>
<th>County</th>
<th>HMD Funds Allocation FY86-87 ($)</th>
<th>Case Management Only</th>
<th>Outreach/Case Management</th>
<th>Drop-in/Socialization</th>
<th>Shelter, Crisis, and Transitional Residences</th>
<th>Advocacy</th>
<th>Other</th>
<th>Administration</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>7,467,360</td>
<td>14</td>
<td>27</td>
<td>10</td>
<td>44</td>
<td>—</td>
<td>—</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td>San Diego</td>
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<td>—</td>
<td>39</td>
<td>18</td>
<td>43</td>
<td>—</td>
<td>—</td>
<td>—</td>
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</tr>
<tr>
<td>Orange</td>
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<td>—</td>
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<td>24</td>
<td>—</td>
<td>—</td>
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<tr>
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<td>34</td>
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<td>5^a</td>
<td>7^c</td>
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<tr>
<td>Alameda</td>
<td>688,883</td>
<td>—</td>
<td>11</td>
<td>51</td>
<td>12^h</td>
<td>10^d</td>
<td>16</td>
<td>—</td>
<td>100</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>673,431</td>
<td>—</td>
<td>54</td>
<td>7</td>
<td>39</td>
<td>—</td>
<td>—</td>
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</tr>
<tr>
<td>Sacramento</td>
<td>847,215</td>
<td>—</td>
<td>34</td>
<td>3</td>
<td>63</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>100</td>
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<tr>
<td>San Francisco</td>
<td>1,027,485</td>
<td>33</td>
<td>11</td>
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<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
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<tr>
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<td>—</td>
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<td>—</td>
<td>—</td>
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</tr>
<tr>
<td>Fresno</td>
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<td>23</td>
<td>59</td>
<td>—</td>
<td>18</td>
<td>—</td>
<td>—</td>
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</tr>
<tr>
<td>Sonoma</td>
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<td>—</td>
<td>22</td>
<td>—</td>
<td>68</td>
<td>—</td>
<td>—</td>
<td>10^e</td>
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<td>Butte</td>
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<td>—</td>
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<td>—</td>
<td>—</td>
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</tr>
<tr>
<td>Placer</td>
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<td>—</td>
<td>100</td>
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<td>—</td>
<td>—</td>
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<td>Yolo</td>
<td>109,901</td>
<td>—</td>
<td>71</td>
<td>—</td>
<td>10</td>
<td>—</td>
<td>—</td>
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<tr>
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<td>—</td>
<td>25</td>
<td>6</td>
<td>69</td>
<td>—</td>
<td>—</td>
<td>10</td>
<td>100</td>
</tr>
<tr>
<td>Tehama</td>
<td>31,011</td>
<td>—</td>
<td>29</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>61^f</td>
<td>100</td>
</tr>
<tr>
<td>Mariposa</td>
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<td>29</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>71^f</td>
<td>100</td>
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</tbody>
</table>

**Total** 15,478,006

**SOURCES:** County Short-Doyle plans, counties' applications for HMD funds, and telephone interviews with HMD program administrators.

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

^aAdvocacy for entitlements.

^bIncludes advocacy for entitlements (General Assistance and SSI) and housing referrals.

^cLoan program.

^dMobile crisis services.

^eVocational/rehabilitation services.

^fIncludes funds for vouchers for shelters, motels, or hotels.
DELIVERY OF SERVICES

Overview

The county's philosophy about whether services should be contracted out and the pre-existing service delivery networks 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.

In terms of service approaches, the counties' programs differ in how they define the case management function and the comprehensiveness of services that it includes. Nearly all the programs prepare written service plans. Involvement of relatives or other service providers in service plan preparation is rare, in part because many HMD individuals have no relatives or will not give the information or permission to involve them.

The majority of services are provided through contract agencies—generally large, established providers already operating in the county. 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.

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.

Across all counties, reporting requirements for both funds and services are minimal. Current requirements do not generate enough information at either the state or local level to
Table 4.2

NUMBER OF HMD-FUNDED BEDS

<table>
<thead>
<tr>
<th>County</th>
<th>Shelter</th>
<th>Crisis</th>
<th>Transitional</th>
<th>Long-Term</th>
<th>Supportive or Independent Living</th>
<th>Total</th>
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<td>20</td>
<td>85</td>
<td>63</td>
<td>33</td>
<td>278</td>
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<td>San Diego</td>
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<td>-</td>
<td>-</td>
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<td>Orange</td>
<td>40a</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>40</td>
</tr>
<tr>
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<td>-</td>
<td>20</td>
<td>-</td>
<td>57</td>
<td>132</td>
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<tr>
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<td>-</td>
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<td>-</td>
<td>-</td>
<td>84</td>
</tr>
<tr>
<td>San Bernardino</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>44</td>
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<tr>
<td>Sacramento</td>
<td>-</td>
<td>14b</td>
<td>51</td>
<td>-</td>
<td>-</td>
<td>65</td>
</tr>
<tr>
<td>San Francisco</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ventura</td>
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<td>12</td>
<td>-</td>
<td>-</td>
<td>12</td>
</tr>
<tr>
<td>Fresno</td>
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<td>-</td>
<td>30</td>
<td>-</td>
<td>-</td>
<td>32</td>
</tr>
<tr>
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<td>12</td>
<td>-</td>
<td>12</td>
<td>-</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Butte</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Placer</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Yolo</td>
<td>9a</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Mendocino</td>
<td>-</td>
<td>-</td>
<td>3d</td>
<td>-</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Tehama</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mariposa</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>370</td>
<td>46</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 having a total of three beds.

support effective management and assess the relative effectiveness of the various approaches to serving clients.

Approaches to Serving Clients

We identified at least three approaches that counties use to serve individual clients. Our typology is, of course, merely representative, and individual counties may combine approaches, depending on their priorities. The approaches are:

1. The joint outreach/case manager model
2. The separate outreach and case management model
3. The provider-oriented model

We discuss each below.

1. The joint outreach/case manager model—illustrated by Orange and Yolo counties—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 manager staff are responsible for "orchestrating" service delivery from various providers to help their clients obtain subsistence, shelter, entitlements, housing, and mental and physical health services. The approach is often characterized by a low caseload per worker, 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.

Counties who have adopted this model handle those HMD cases that are accepted for treatment by county mental health in two different ways.

In most instances, the case is transferred to county mental health and becomes indistinguishable from other cases in the county mental health caseload. County mental health case managers become responsible for the case. They monitor medication, intake, and stay in residential facilities—including board and care—and provide some counseling and crisis intervention services. The caseload of these managers averages 50 to 60, three to four times higher than the outreach/case manager caseload.

Alternatively, the outreach/case manager may remain with the case even while mental health treatment services are being provided. In five counties, the outreach worker continues as the case manager indefinitely. However, in four out of five of these counties, the outreach worker is also a case manager for the county department of mental health, so the outreach clients become part of the regular caseload. Over time, the cumulative caseload of these managers will probably continue to increase; eventually, it may become unmanageable.

(2) The second model—illustrated by San Diego County—separates the outreach and case management functions. The primary responsibility of the outreach worker is to engage the HMD and refer them as quickly as possible to a mental health service provider. Clients are then provided treatment services, and their cases are managed according to the current practice in the county's mental health system.

(3) The third model—illustrated by Alameda County—relies primarily, if not exclusively, on a group of specialized service agencies. Any outreach is provided separately by and for each individual agency. Case management may also be provided, but it is generally limited to assessment, referral, and follow-up services offered by each specific agency. The caseload per manager generally varies between 30 and 40. Continuity of services generally requires that the client continue to show up at the provider. No comprehensive service case management is attempted unless the provider itself delivers the full range of services. Contracted providers in at least two counties deliver such a range of services.

All three approaches involve preparing some kind of written service plan for each client, as specified in the HMD legislation. Usually, this consists of a one-page checklist of services needed and a space available to write in whether the service was eventually provided. Regardless of approach, involvement of relatives and other service providers in preparing the service plan is rare. Our survey indicates that about one in three HMD have no ongoing contact with relatives, and service providers indicate that many who do will not give the information to locate or permission to involve them. An exception is 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 over time 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

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2See Sec. III, "Resources and Use of Services."
because of resource constraints, and in part because of the difficulties inherent in serving a mobile, unstable, and often chronically ill population.

Reliance on Contract Services

Most of the 17 counties provide the majority of their homeless services through contract agencies (Table 4.3). Only three counties choose to provide all services directly (Placer, Tehama, and Mariposa, through vouchers); these counties are among the smallest in our sample. Of the 12 larger counties in our sample, only San Bernardino allocates less than 50 percent of its HMD budget to contract services, and five counties (Santa Clara, Sacramento, San Francisco, Ventura, and Mendocino) provide all of their HMD services through contract agencies.

In the 10 counties providing services through a mix of contract and direct arrangements, drop-in/socialization centers, shelters, and other residential services are always provided through contract agencies, reportedly because county mental health departments had little or no experience in directly operating such services.

Table 4.3

DIRECT SERVICE PROVISION VERSUS EXTERNAL CONTRACTING
IN 17 COUNTIES’ PROGRAMS: 1986–1987

| Percentage of Homeless
<p>| Budget Allocated to: |
|----------------------|----------------------|</p>
<table>
<thead>
<tr>
<th>County</th>
<th>Direct Services</th>
<th>External Contracts</th>
<th>Services Provided Directly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>42</td>
<td>58</td>
<td>Outreach/case management</td>
</tr>
<tr>
<td>San Diego</td>
<td>39</td>
<td>61</td>
<td>Outreach/case management</td>
</tr>
<tr>
<td>Orange</td>
<td>33</td>
<td>67</td>
<td>Outreach/case management</td>
</tr>
<tr>
<td>Santa Clara</td>
<td>0</td>
<td>100</td>
<td>None</td>
</tr>
<tr>
<td>Alameda</td>
<td>18</td>
<td>82</td>
<td>Mobile crisis</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>54</td>
<td>46</td>
<td>Outreach/case management</td>
</tr>
<tr>
<td>Sacramento</td>
<td>10^a</td>
<td>90</td>
<td>Outreach/case management</td>
</tr>
<tr>
<td>San Francisco</td>
<td>0</td>
<td>100</td>
<td>None</td>
</tr>
<tr>
<td>Ventura</td>
<td>0</td>
<td>100</td>
<td>None</td>
</tr>
<tr>
<td>Fresno</td>
<td>23</td>
<td>77</td>
<td>Case management</td>
</tr>
<tr>
<td>Sonoma</td>
<td>22</td>
<td>78</td>
<td>Outreach/case management</td>
</tr>
<tr>
<td>Butte</td>
<td>17</td>
<td>83</td>
<td>Outreach/case management</td>
</tr>
<tr>
<td>Placer</td>
<td>100</td>
<td>0</td>
<td>Outreach/case management</td>
</tr>
<tr>
<td>Yolo</td>
<td>40</td>
<td>60</td>
<td>Outreach/case management</td>
</tr>
<tr>
<td>Mendocino</td>
<td>10^b</td>
<td>90</td>
<td>None</td>
</tr>
<tr>
<td>Tehama</td>
<td>100</td>
<td>0</td>
<td>Outreach/case management</td>
</tr>
<tr>
<td>Mariposa</td>
<td>100</td>
<td>0</td>
<td>Outreach/case management</td>
</tr>
</tbody>
</table>

SOURCES: County Short-Doyle plans; county HMD program proposals; and interviews with program administrators.

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

^aFunds for Homeless Coordinator and case management.

^bAdministrative funds exclusively.
In contrast, case management and/or combined outreach/case management are nearly always directly provided in full (9 counties) or in part (3 counties) by the county's department of mental health. Fresno contracts for outreach services, but performs case management directly. Yolo equally divides these activities between the department of mental health and a contractor. Only three counties (Sacramento, San Francisco, and Mendocino) fully contract out these services.

The strong reliance on contract agencies and the tendency to limit direct services to case management and outreach reflect county mental health departments' perceptions of their strengths and their roles in serving the HMD. When the HMD funds became available, county mental health departments generally set up in-house programs to provide services with which they already had experience. Most county mental health departments provide some case management services to their traditional clientele, and those counties that served the HMD and at-risk populations prior to the HMD program provide case management services to these clients as well. Similarly, county mental health departments typically accepted referrals of HMD from other agencies, the police, or individuals in the community; thus the departments previously filled a role that now constitutes a significant portion of the function of homeless outreach programs. In fact, San Diego and Placer counties each established a homeless outreach team prior to the HMD legislation and used HMD funds to increase the number of teams.

Another important determinant of reliance on contract services is the county's philosophy regarding how to conduct effective outreach. On the one hand, the few counties that rely exclusively on contract agencies to provide outreach feel that its special status—the initial HMD program contact for many clients—requires that it be provided by a program or agency without obvious ties to the traditional mental health system, which many of the HMD wish to avoid. On the other hand, most counties feel that the outreach workers themselves— their background, attitudes, and approach to HMD clients—are more important determinants of success than their institutional affiliations.

Just as the pre-existing service delivery network strongly influenced how counties set their service priorities, and consistent with legislative intent, counties generally selected contractors who were already operating in their area. The majority of private agencies receiving county mental health department contracts for HMD services were large, well-established social service agencies with considerable experience in serving either the general homeless or the mentally ill. The only exceptions were small shelters (i.e., those with fewer than 10 beds); these tended to be run by individuals in modified single-family residences. 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.

3Only Alameda, Ventura, and Santa Clara do not fund case management or combined outreach and case management services with HMD funds.
• Outreach, socialization, and crisis/transitional residential services to HMD population are generally run separately from other agency services.
• In shelters that served and continue to serve all homeless, HMD funds are used to enhance services to the HMD population.

Organization and Management

Program Coordinators. All of the county departments of mental health in our sample, with the exception of San Diego whose mental health systems are regionalized, have designated a single individual to function as the Homeless Coordinator. With the exception of the Los Angeles County homeless coordinating unit, which has a staff of six, no additional staff are assigned to that function. In the larger counties the HMD coordinating function is generally a full-time job; in all other counties, the coordinator role is a part-time responsibility in addition to the individual’s primary role in the county mental health department.

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 HMD 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. In three counties, the coordinator reports directly to the director, adding this function to primary duties such as Long-Term Care Coordinator, Community Care Division Manager, or Community Care Chief.

The HMD coordinators usually have considerable experience in the mental health field, and many have been with the county departments in which they work for several years. At the time of our study, 10 of the coordinators held Master’s degrees in social work or counseling or were Licensed Clinical Social Workers (LCSW). More than half had significant administrative experience in addition to or instead of clinical experience. The remaining coordinators included two clinical PhDs, one Master’s degree in public administration (MPA), a nurse’s aide, and a high school graduate with counseling experience.

Training. In general, there are no formal training programs for those working with the HMD or for the Homeless Coordinators. However, counties are currently using a range of informal training activities, and some are planning more formal programs. The case studies provide typical examples.

Orange County has conducted two countywide in-service training programs that focus on identifying the homeless mentally ill and suggest techniques for interviewing and engaging them. The Homeless Coordinator believes more training is needed, especially for the staff of community agencies providing services. The most acceptable type of training from the perspective of these agencies is techniques or methods to improve service delivery. Two topics mentioned were recognition of mental illness and program intake procedures.

Perhaps because it is such a small county, Yolo relies on solving individual problems as they arise. This is done in collaboration with either the Transitional Care Coordinator or the county outreach worker. The meetings of the homeless team also provide a forum for discussing problems.

Alameda had not provided any formal training for contractors operating under the HMD program at the time of our visit. However, the Homeless Coordinator is developing a series of formal workshops that will be incorporated into the monthly contractor meetings. The topics identified for these workshops include:
• Violence and aggressive clients
• Assessment of clients
• The dual diagnosed client
• AIDS information and prevention
• Housing (Sec. 8 and other low-cost options)
• Public assistance: legal, medical, Aid to Families with Dependent Children (AFDC), SSI
• Stress reduction
• Behavioral issues—schizophrenics and counseling
• Setting limits—saying no to clients

**Reporting Requirements.** During the start-up period for the HMD program, both the state and the counties assigned first priority to getting services operating. Accountability for funds and services was considered later. As a consequence, current reporting requirements by the state 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 branch 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 to let managers 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 case, there is no consistency at the state level—and usually not at the county level—about what information is kept, or how to annotate or report the progress of a case. The individual service providers and, consequently, the counties and the state have no ready 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.

We have already noted the difficulties we encountered in trying to gather **aggregate data** for our description of program activities. Specific problems in interpreting the data from the quarterly report to the state illustrate the lack of adequate management information.

(1) Some of the categories in the report are vaguely labeled, and there are no instructions accompanying the report that define the categories. Each provider in each county must interpret the label and decide what information is being requested. The inconsistency that inevitably results makes statewide comparisons exceedingly difficult.

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*There 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.*
(2) A one-week reporting window may not adequately capture rare events such as housing placements.

(3) It was not always clear whether the service activity reported was directly paid for with HMD funds or represented other related activities. For example, if HMD funds support a counselor in a food line but do not pay for the meals, are all clients going through the line included in the unduplicated client count?

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. Staff feel that minimizing this kind of information gathering increases their ability to engage and serve the HMD. However, these concerns will have to be balanced against the information needed for effective management of the program and for assessing the effects of the counties' alternative approaches to serving the HMD.

IMPLEMENTATION PROGRESS

Overview

The counties encountered few difficulties in implementing their programs. Reliance on the existing service network and on experienced service providers facilitated implementation. However, services that required establishing a new facility, e.g., a drop-in center or shelter or residential facility, were often delayed because of local opposition. This problem persists. Counties are attempting to circumvent it by reducing the size of the proposed new facilities or by using existing facilities for which they do not need new permits.

Details of Implementation Progress

Counts were requested to submit their applications for the HMD Targeted Funds by November 1985. Implementation of county 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. Only one county—Mendocino—spent its entire amount, and two counties spent essentially nothing (see Table 4.4). In general, smaller counties were able to move more rapidly than larger ones, both because they had less money to spend and because they tended not to contract out for service delivery, relying instead on fee-for-service arrangements with shelters, hotels, and motels to provide temporary shelters.

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
### Table 4.4

<table>
<thead>
<tr>
<th>County</th>
<th>Percentage of FY 1985-86 Allocation Spent</th>
<th>Percentage of FY 1986-87 Allocation Spent</th>
<th>Services Not Fully Functional as of Summer 1987</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles</td>
<td>&gt; 50</td>
<td>75</td>
<td>Crisis and transitional residential facilities</td>
</tr>
<tr>
<td>San Diego</td>
<td>1</td>
<td>60</td>
<td>14-day residential</td>
</tr>
<tr>
<td>Orange</td>
<td>25</td>
<td>75</td>
<td>Drop-in center</td>
</tr>
<tr>
<td>Santa Clara</td>
<td>40</td>
<td>100</td>
<td>Shelter</td>
</tr>
<tr>
<td>Alameda</td>
<td>NA</td>
<td>75</td>
<td>Shelter, mobile crisis</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>50–75</td>
<td>50–75</td>
<td></td>
</tr>
<tr>
<td>Sacramento</td>
<td>50–75</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>San Francisco</td>
<td>&lt; 100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Ventura</td>
<td>0</td>
<td>5</td>
<td>Transitional residential</td>
</tr>
<tr>
<td>Fresno</td>
<td>&lt; 50</td>
<td>&gt; 75</td>
<td></td>
</tr>
<tr>
<td>Sonoma</td>
<td>&gt; 75</td>
<td>100</td>
<td>Case management</td>
</tr>
<tr>
<td>Butte</td>
<td>&lt; 50</td>
<td>100</td>
<td>Outreach</td>
</tr>
<tr>
<td>Placer</td>
<td>&gt; 75</td>
<td>50–75</td>
<td></td>
</tr>
<tr>
<td>Yolo</td>
<td>40</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Mendocino</td>
<td>100</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Tehama</td>
<td>&lt; 50</td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Mariposa</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

**Sources:** Homeless Coordinator and program director interviews.

**Notes:** This table reflects implementation status as of mid-1987. Several counties reported that all services were scheduled to be operational by the end of calendar year 1987. NA means not available. Counties are listed in decreasing order of population size.

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. For example, the two drop-in centers planned for Orange County were both delayed because local residents pressured officials to disapprove the sites selected. One center opened at a temporary location and has now moved to its permanent home at the Santa Ana YMCA, where a new use permit was not needed. The second facility is scheduled to open soon—but at a different site from the original plan. Ventura has experienced numerous delays in implementing the major planned component of its program: a crisis residential facility. Unable to go forward, the county is establishing two transitional residential facilities of six beds each.
SELECTED OUTCOMES

Overview

Currently, the counties' programs appear to be most effective in providing basic necessities. The programs have been less successful in moving individual HMD into entitlement and mental health treatment programs and eventually into long-term housing. Counties cite the difficulties in negotiating the entitlement program system, capacity constraints for mental health and housing, and lack of residential alternatives as the biggest stumbling blocks in these areas.

At present, the program is not fully meeting the needs of all HMD, as suggested by the findings of our survey of the homeless described in Sec. III. Only half of the HMD interviewed receive some form of assistance.

All of the counties minimize the use of involuntary commitment. Evidence suggests that most HMD can effectively be engaged 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 those hard to reach include severity of mental illness, length of homelessness, transience, and the types of services being offered—especially mental health services.

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 (they are known as dual diagnosed clients). HMD program staff indicate that their lack of experience dealing with this problem and lack of access to substance abuse treatment programs make it difficult to effectively serve the dual diagnosed.

The state HMD funding has improved coordination within counties and among service providers. And the county programs have increased community awareness of the special needs of the HMD. However, the state program has generally not resulted in the development of "new ways" to serve this population. Rather, it has expanded existing services and helped the HMD to access them.

Service Use

Our 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 varying in service delivery and case management practices. However, we did seek information to determine the extent to which 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. As we have already noted, data limitations hampered our efforts in this assessment. Some counties do not keep the necessary data, others cannot retrieve them readily. When data are available, they are often not readily comparable across agencies or counties. Thus, our assessment should be viewed as preliminary.

Subsistence Services. Currently, county programs appear 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 HMD are of this nature, reflecting the priority that nearly all
counties placed on providing basic services. Of the HMD whom we surveyed and who reported receiving some help from any service staff, more than 85 percent indicated they have received help with subsistence services. The county programs seem to have been less successful at moving individual HMD into entitlement and mental health treatment programs. Staff interviewed often emphasized difficulties and constraints they encountered in securing these services.

Entitlements. Outreach workers and case managers assigned high priority to helping the HMD obtain General Assistance or 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. Generally, agencies do not collect statistics on the number of SSI, General Assistance, and veterans' benefits applications they assist HMD to file; nor do they know the rate of approval on these applications. One indication of level of activity in this area for all county services—including the HMD program—suggests that such assistance is being provided to about one out of five HMD who reported having been helped by service staff in the "past month."

Nearly all our service staff respondents emphasized the time consuming nature of the application process for both SSI and General Assistance, the high rate of first-time rejections of applications, and the high likelihood that their clients might not be able to secure continuing benefits because of the periodic verification requirements of these programs. This is particularly true in the first year of receiving SSI, when the review process is the most intensive. General Assistance also requires periodic recertification.

For clients unable to manage on their own, inadequate funding for or unavailability of representative payees presents additional barriers to entitlements. Respondents told us that the dual diagnosed clients are particularly susceptible to this constraint because of their history of "mismanaging" 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 functioning as representative payee.

The case studies (App. I) offer a range of examples. Alameda County, through the Berkeley Multiservice Center, offers both a small representative payee and a money management program. At the time of our visit there were 35 clients in the representative payee program and another 15 to 25 in the money management program. The program helps clients establish a budget, with particular emphasis on providing adequate funds for rent and food, and then assists clients in living within the budget. For some clients this means receiving a small amount of money each day for discretionary spending. More typically, clients get spending money once a week. In contrast, Orange County has no money management or representative payee programs that are designed to serve the HMD.

Overall, counties reported to the state that they delivered 951 and 669 units of money management during one-week periods in March 1987 and in June 1987, respectively. Four counties account for two-thirds of the money management activities reported: Los Angeles, Alameda, Santa Clara, and Sonoma.

Mental Health Services. Although they are authorized to use HMD funds to provide certain mental health treatment services—including day, outpatient, and specific 24-hour

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4 As reported by the counties to the State Department of Mental Health.
5 See Sec. III, Table 3.10.
6 See Sec. III, Table 3.8.
7 See Sec. III, Table 3.10.
8 SSI can require an individual to have a representative payee as a condition of receiving benefits.
services—very few counties used HMD funds to provide mental health services to the HMD. Table 4.5 shows the number of mental health service units provided with HMD funds during one-week periods in March and in June of 1987, respectively. Los Angeles County accounts for the majority of the services. It provided about 80 percent of the HMD-funded medication and about 50 percent of the 24-hour care units. A handful of counties account 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. And 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) to provide mental health services to clients referred to them through HMD program activities.

Again, the case studies offer a range of examples concerning the integration of the HMD program into the county mental health service system. Orange County has located its HMD outreach/case management function within the Adult Aftercare program in the Orange County Department of Mental Health—this program also provides case management services for clients with chronic mental disorders. This organizational proximity has resulted in fairly close coordination between the HMD program and subsequent services delivered by the Continuing Care Unit. According to the Homeless Coordinator, one of the county clinics that sees the largest number of HMD clients has made considerable efforts to adjust operations to meet the needs of this population. The most dramatic illustration of this flexibility is a client who is on SSI and chooses to live on the Santa Ana riverbed. Both the Homeless Unit and the Continuing Care Unit have tried working with him to find a more suitable living arrangement, but

Table 4.5

HMD-FUNDED MENTAL HEALTH SERVICE UNITS BY SIZE OF COUNTIES, MARCH AND JUNE 1987

<table>
<thead>
<tr>
<th>Population Size of Counties (Number of counties)</th>
<th>March</th>
<th>June</th>
<th>March</th>
<th>June</th>
<th>March</th>
<th>June</th>
<th>March</th>
<th>June</th>
<th>March</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>3+ million (1)</td>
<td>672</td>
<td>622</td>
<td>696</td>
<td>866</td>
<td>222</td>
<td>256</td>
<td>222</td>
<td>183</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>1-3 million (5)</td>
<td>60</td>
<td>24</td>
<td>603</td>
<td>387</td>
<td>65</td>
<td>29</td>
<td>6</td>
<td>59</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>.5-1 million (7)</td>
<td>67</td>
<td>69</td>
<td>7</td>
<td>6</td>
<td>87</td>
<td>13</td>
<td>110</td>
<td>45</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>All others (43)</td>
<td>82</td>
<td>60</td>
<td>117</td>
<td>65</td>
<td>79</td>
<td>22</td>
<td>56</td>
<td>14</td>
<td>33</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>881</td>
<td>775</td>
<td>1333</td>
<td>1324</td>
<td>453</td>
<td>319</td>
<td>394</td>
<td>271</td>
<td>63</td>
<td>20</td>
</tr>
</tbody>
</table>

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

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

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

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

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.
he has steadfastly refused such opportunities. He has, however, provided his case manager with a map of the riverbed, indicating the three areas he is most likely to spend time. If he has not been in for an appointment for about two weeks, the case manager will go looking for him. The case manager has also worked with him to plan some trips out of the area so that his budget will last. The Continuing Care Unit estimates that about 5 to 10 percent of its caseload are HMD clients, although many more would be considered at risk of becoming homeless.

By contrast, Alameda County’s HMD service providers indicate they do not have strong referral ties with the county mental health service. There is a strong self-help group influence in Alameda County which has been antagonistic to the traditional mental health system. As an alternative, the HMD service providers offer peer support and counseling. A contributing factor to this lack of integration and reluctance to refer is the consideration expressed by many officials that Alameda County mental health services are operating at capacity and waiting times for appointments at some clinics can be as long as several months.

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

Counties minimized the use of involuntary hospitalization through their programs. On average, less than one involuntary hospitalization per week per county was initiated through the programs. Los Angeles accounts for roughly half of the involuntary hospitalizations. Service staff expressed reluctance to use the involuntary commitment procedures other than in crisis situations primarily for two reasons. One reason is the voluntary nature of the program itself; some staff felt their ability to gain the trust of the HMD might be affected if it became known that they initiated involuntary commitment procedures. Second, they indicated that involuntary commitments make the situation worse for the HMD if they are released from the hospital before being fully stabilized. Furthermore, at their return to the street, their belongings and their special sleeping place may have been taken by others.

Long-Term Housing. Permanent placement of the HMD in assisted or independent living arrangements is the state’s ultimate goal for the program. Counties are requested to report to the state the number of placements made in board-and-care facilities (see Table 4.6). Overall, one placement in board and care was made for every 50 persons reported served during a week. Most of these placements occurred in three counties: Los Angeles, Santa Clara, and Fresno.

Counties could provide neither actual figures nor estimates of placements in independent or other types of housing. Most indicated that few such placements were made and stressed the lack of low-income housing, particularly in the larger counties, and the need for additional long-term beds. They estimated that the number of long-term beds needed ranged from 20 in smaller counties to 500 in larger counties.

Percent of HMD Served. Despite the success of county programs in providing some kinds of services to the HMD, they are not fully meeting all HMD needs as already noted in Sec. III. This gap between needs and services does not appear to be the result of ineffective

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11Although the figures shown in Table 4.6 are indicative of level of activity, we believe it is inappropriate to annualize these figures; they include individuals already in care (for whom HMD funds are used for assistance if a day is missed), individuals being sheltered temporarily in empty board-and-care beds, and individuals that may have been placed more than once. In addition, some counties reported placements over more than one week. Finally, one week is too short a time to track housing placements, which may take several weeks to accomplish.
Table 4.6
PLACEMENTS IN BOARD-AND-CARE HOMES BY SIZE OF
COUNTIES DURING ONE WEEK

<table>
<thead>
<tr>
<th>Population of County (Millions)</th>
<th>Number of Counties</th>
<th>December 1986</th>
<th>March 1987</th>
<th>June 1987</th>
</tr>
</thead>
<tbody>
<tr>
<td>3+</td>
<td>1</td>
<td>27</td>
<td>55</td>
<td>77</td>
</tr>
<tr>
<td>1-3</td>
<td>5</td>
<td>44</td>
<td>35</td>
<td>6</td>
</tr>
<tr>
<td>.5-1</td>
<td>7</td>
<td>16</td>
<td>26</td>
<td>16</td>
</tr>
<tr>
<td>.1-.5</td>
<td>20</td>
<td>14</td>
<td>46</td>
<td>13</td>
</tr>
<tr>
<td>.1</td>
<td>23</td>
<td>5</td>
<td>11</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>55</td>
<td>106</td>
<td>172</td>
<td>130</td>
</tr>
</tbody>
</table>

SOURCE: Counties' reports to the State Department of Mental Health.
NOTES: Figures in this table are for the weeks of December 15-21, 1986, March 23-29, 1987, and June 22-28, 1987. Ten and 22 counties did not file reports in March and June, respectively, representing $600,000 and $4,000,000 in HMD funds, respectively. Thus, comparisons over time should not be made.

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 a large proportion of the HMD are not being served because needs exceed capacity. Many of the service providers, especially in the largest 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 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 higher proportion of non-HMD, from 60 to 70 percent, had also received no such help.12 Those not receiving help in both groups indicated that they had not been offered assistance.

Targeting the HMD

Table 4.7 shows the mental health status and demographic characteristics of the persons served by the HMD program, by type of service. For most characteristics, the table displays a value averaged across all interviewed agencies and a low and high range. Because the numbers displayed are based on information collected in telephone interviews with experienced service delivery staff rather than from actual counts, they should be interpreted as being indicative of the population served.

Consistent with the emphasis placed on subsistence services, the counties' programs primarily serve the currently homeless. Less emphasis has been placed on persons "at risk" of homelessness. The latter population is more difficult to identify and needs services—long-term

12 See Sec. III, Table 3.10.
Table 4.7
CHARACTERISTICS OF POPULATION SERVED BY HMD PROGRAMS, BY TYPE OF SERVICE

<table>
<thead>
<tr>
<th>Characteristics of Population Served</th>
<th>Services</th>
<th>Outreach</th>
<th>Drop-in</th>
<th>Shelter</th>
<th>Transitional Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent homeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td>86</td>
<td>82</td>
<td>95</td>
<td>64</td>
</tr>
<tr>
<td>Range</td>
<td></td>
<td>75-100</td>
<td>80-90</td>
<td>90-100</td>
<td>25-100</td>
</tr>
<tr>
<td>Percent mentally disabled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td>95</td>
<td>67</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td>Range</td>
<td></td>
<td>70-100</td>
<td>40-75</td>
<td>95-100</td>
<td>NA</td>
</tr>
<tr>
<td>Percent severely mentally disabled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td>64</td>
<td>45</td>
<td>42</td>
<td>90</td>
</tr>
<tr>
<td>Range</td>
<td></td>
<td>30-100</td>
<td>10-70</td>
<td>15-80</td>
<td>75-100</td>
</tr>
<tr>
<td>Percent with dual diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td>54</td>
<td>57</td>
<td>55</td>
<td>70</td>
</tr>
<tr>
<td>Range</td>
<td></td>
<td>15-95</td>
<td>30-70</td>
<td>10-85</td>
<td>45-100</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td></td>
<td>20-45</td>
<td>22-50</td>
<td>20-40</td>
<td>20-40</td>
</tr>
<tr>
<td>Percent male</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td></td>
<td>70</td>
<td>76</td>
<td>80</td>
<td>58</td>
</tr>
<tr>
<td>Range</td>
<td></td>
<td>60-82</td>
<td>65-85</td>
<td>60-90</td>
<td>35-82</td>
</tr>
<tr>
<td>Percent non-white</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td></td>
<td>8-75</td>
<td>5-68</td>
<td>8-90</td>
<td>NA</td>
</tr>
</tbody>
</table>

SOURCES: Telephone interviews with or client profiles prepared by providers of service to the HMD in 17 counties.
NOTES: Figures in this table should be interpreted as being indicative of the types of clients served by HMD service providers; averages are relative to service providers, not to counties. NA means not available.
aEstimated as percent of the mentally disabled served.
bCharacterizes 70 percent or more of the persons served.
cExcludes two shelters for women only.
dAlthough there are variations within counties, the percent of non-white served varies more extensively across counties. Counties with large central cities generally serve a majority of non-white clients.

case management, mental health service support, and day treatment—that are currently not emphasized by the counties' programs. Overall, the counties have adopted a "worst first" approach to the homeless problem.

Outreach services focus on the severely mentally disabled. In contrast, less than half of the persons receiving shelter and drop-in services are described as severely mentally disabled. This may reflect in part the 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 a lower percentage (about 50 percent) of persons who are both mentally disabled and substance abusers than is found among the HMD population (about 70 percent). Service providers, most particularly those with 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.

The age and gender distribution of the population served is similar to that of the general HMD population, with two significant exceptions. Shelters generally seem to serve males in greater proportion than females; indeed, few shelters specialize in serving women. By contrast, transitional facilities serve almost an equal proportion of women.

Engaging the HMD

For the HMD, outreach is often the door into services. However, HMD are difficult to serve because they may: (1) Have problems adjusting to and meeting the requirements of residential facilities, such as transitional residential facilities and board and care; (2) lack instrumental, social, and cognitive skills necessary to obtain services; (3) fear involuntary hospitalization and medication, and therefore distrust the mental health system; (4) have symptoms of mental illness such as paranoid delusions and other psychotic symptoms that cause fear and avoidance of service providers. In addition, service providers are often reluctant to serve mentally ill persons either because they are disruptive or because the service providers are not trained to work with this difficult population.

We obtained information about county outreach activities from our studies and from telephone interviews with the Homeless Coordinator and program directors of agencies providing outreach activities. In addition, each of the site visits to the four counties included shadowing outreach workers in the field.

Types of Activities. 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. Roughly in order of decreasing importance, counties practice one, or some combination, of the following activities:

- **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. These referrals may be made informally or as the result of a formal agreement between the outreach team and the concerned agencies. A critical element in this form of outreach is educating service provider staff and the community about techniques for dealing with the HMD and the services available to them.

- **Active agency outreach**—approaching an individual at facilities providing unconditional services to the homeless, including soup kitchens, drop-in centers, shelters, emergency rooms, and social service agencies.

- **Active street outreach**—engaging individuals in public or accessible areas including parks, beaches, riverbeds, campgrounds, abandoned buildings, bus and train stations, and freight yards. The approach is made without knowing the individual's living arrangements or mental health status.

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13See Sec. III, Table 3.3.
14See Sec. III, Table 3.4.
• **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 from service agencies or individuals about crisis situations such as suicide attempts, violence, or aberrant behavior. This approach may be closely linked with the involuntary hospitalization process.

All of the counties providing outreach services employ some combination of active outreach, agency referrals, and self-referral. Often a single agency uses several approaches. For example, in Orange County the outreach team operates out of a drop-in/socialization center, actively seeks the HMD on the street, receives referrals from agencies, and has new clients drop by the socialization center. Only two counties, Yolo and Alameda, include crisis intervention as part of their HMD-funded program.

With few exceptions, street outreach constitutes from 10 to 25 percent of the outreach contacts made. Only 2 of the 17 counties surveyed, Santa Clara and Sacramento, reported making more than 50 percent of their contacts “on the street.” The remainder of their effort consisted of seeking HMD individuals at other service providers or through referrals from other agencies. Nearly half of the counties reported their outreach effort from drop-in centers.

Counties with multiple outreach teams engaged in more specialized outreach efforts. Each of these counties had one outreach team that only conducted outreach at specific agencies, such as shelters. For example:

• An outreach agency in Sacramento identifies HMD individuals staying in shelters and helps them access longer-term support services.

• Employees of advocacy programs in Santa Clara and Alameda visit shelters regularly to help shelter residents obtain social security or General Assistance benefits.

• Santa Clara and Sacramento have outreach teams whose primary activity is to engage HMD on the street.

• Orange County, in a pilot program, outstationed one worker in the General Relief Office. Over a one-month period, 346 clients were contacted, 13 percent of whom were found to be mentally disabled.

None of the counties with multiple outreach teams operate their activities out of a socialization center.

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 somewhere 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 HMD to a range of services. 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 provide bus tokens. The outreach team will also help the indi- 
vidual to obtain General Assistance and social security benefits.

All of the outreach teams reported that some individuals could be engaged immediately, 
while others might take as long as 18 months. They felt that their ability to engage the HMD 
depended on the individual, and also on the services that they were able to offer. As noted in 
the passage above, the HMD usually accept basic services such as food and shelter after the 
first few contacts, but they are much slower to accept mental health services—and indeed, may 
ever accept them.

Generally, outreach staff defined “refusal” to mean their 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 HMD person refused 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.

We asked the outreach programs to estimate the percent of HMD who refused services. 
Reported refusal rates seem to reflect the structure of the outreach program. High rates of 
refusal—60 to 70 percent—were reported by San Diego, a county that limits engagement 
Attempts to six, and by an outreach program in San Francisco that predominantly offers men- 
tal health services. Other counties’ refusal rates ranged from a few to 30 percent. Estimates at 
the lower range generally came from outreach workers who believe that with time they can 
eventually engage almost everyone.

Explanations differed for why the HMD refuse services. County mental health workers 
attributed refusals to the nature of the individual’s mental illness, explicitly noting paranoia 
and psychoses. However, the contract outreach programs were split. Fifty percent of them 
attributed refusal to the individual’s mental illness; the remaining 50 percent also cited the 
individual’s distrust of the mental health system. In addition, the presence of one or more of 
the following characteristics makes it more difficult to establish contact and build a rapport 
with the HMD:

• Homelessness longer than 6 months
• Substance abuse
• Previous negative experience with mental health services
• Transience

County officials and outreach staff identified a variety of factors that contribute to suc- 
cessful 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. Other 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
• Educated staff in other agencies
• Dedicated and resourceful personalities
• Experience with drug or alcohol abuse counseling and/or treatment
• Supporting 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
- Geographic proximity of service providers
- Ability to assist in obtaining General Assistance or SSI benefits

Characteristics of Outreach Workers. The outreach workers across the counties have varied experience and training. Most have a Master's degree in social work, but some have degrees in nursing, psychology, and divinity. Two outreach programs employ psychiatrists at least part-time. Outreach workers without formal degrees were noted for their extensive field experience or a long history of working in mental health services. Several outreach teams considered previous personal experience with an episode of homelessness to be especially valuable training.

We have already described the three basic models of case management that counties have adopted (joint outreach/case management, separate outreach and case management, and provider-oriented) and the way that they vary in continuity and in the comprehensiveness of services offered. When outreach workers are responsible for managing clients' services on an ongoing basis as well as for initiating new contacts, the workers are pulled between the two activities. Outreach staff report that less than 10 to 30 percent of the contacts they make in an average week are with new clients. As more clients are engaged, the case management function of these workers may expand at the expense of their outreach function.

Yolo County illustrates this tension between outreach and case management. Although its outreach workers are not classified as case managers, in fact they are basically permanent case managers for all their clients. They assess their clients' needs and work with them daily until they are stabilized and linked to county mental health services. Even then, they maintain at least monthly contact with every client they have ever engaged as long as the client stays in the county. They hope to prevent future crises by trying to ensure that relationships with landlords, neighbors, and significant others are working smoothly and by keeping a close eye on money management. Although this sustained contact provides continuity of care, it cannot continue indefinitely. Because an outreach worker never passes responsibility for a client on to another agency, an increased number of client contacts means an ever-increasing caseload for the outreach worker. Although the caseload in Yolo has not yet become burdensome, it is an emerging problem.

Counties are dealing with this conflict in ways that we have already mentioned. At least one county is considering changing case management models and separating the case management and outreach functions. Other approaches include limiting the number of engagement encounters; transferring the case management function to the mental health continuing care managers when the client is placed in a mental health residential facility or in board and care; or appointing a team of outreach/case managers, any one of whom may serve a client.

Some outreach staff report that, over time, they rely increasingly on referrals from other service agencies or on visits to ongoing programs. This reflects in part increased knowledge in agencies and the community about the program and the assistance it can provide them in dealing with the HMD; but this also reflects the higher "payoff" inherent in dealing with referred
clients or clients who are predisposed to accept some services. Overall, our surveys of the homeless indicated that more than half of the HMD interviewed had in the past month been offered assistance from service staff—that includes all service staff in clinics, HMD service providers, and any other service providers. By contrast, only about a third of the homeless who are not mentally disabled were offered such assistance in the past month.  

Coordinating and Linkages

All our respondents felt that the state HMD funds had improved coordination among counties and among the service providers within a given county.

Inter-County Coordination. Inter-county ties benefit homeless programs by facilitating exchange of (1) information about the nature of the HMD population and its needs; (2) knowledge about the success of various services and delivery mechanisms; (3) solutions to problems of community opposition and other implementation difficulties; and (4) ideas for novel programs and approaches.

County mental health departments are formally linked by the State Department of Mental Health and by regional offices. However, almost exclusively these formal ties move information vertically: Department of mental health policy statements and funds flow from Sacramento and/or the regional offices to the counties; and the counties provide Short-Doyle plans, performance statistics, funding proposals, and other information to the regional offices and Sacramento. Horizontal exchanges among counties typically occur on an ad hoc basis during regional or statewide conferences, workshops, and similar activities.

For example, the recent Homeless Fairs held in both Northern and Southern California were attended by representatives of several dozen mental health facilities and homeless programs, as well as by numerous private agencies and homeless activist organizations. These information fairs allowed county homeless program representatives to meet each other and collect information about other county programs and learn about the activities of other agencies. Brochures and information sheets prepared for these fairs also proved useful in exchanging information about specific county programs. These brochures provided the name, address, and telephone number for each program, as well as a short description of the services provided.

Workshops and seminars also allow county representatives to meet and exchange information on specific programs and approaches. For example, the developers of the Los Angeles Skid Row money management program held a series of seminars to describe their program and allow representatives from several counties to ask questions to determine the potential value of the program for their counties.

These mechanisms facilitate the exchange of general program information among counties. However, exchanging information about specific clients may also be needed. A few shelter operators noted that some of their clients travel among cities and counties, staying in a shelter until they have reached the length-of-stay limit and then leaving for another location for the remainder of the month. These kinds of clients may come in contact with homeless program workers in multiple counties, most particularly within the two larger metropolitan areas in the state. Although representatives from all provider agencies within a single county sometimes meet to discuss specific clients who travel in that county, there is no similar mechanism whereby providers from different counties can meet to coordinate treatment for clients who cross county lines.

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15See Sec. III, Table 3.10.
Coordination Among Service Agencies. Institutional coordination of services within a county occurs through three basic mechanisms: the Homeless Coordinator, regular meetings of all service providers, and case management and case referrals between providers.

We have already discussed the role of the Homeless Coordinator in monitoring contracts, advising contractors, and supervising in-house programs. Because the coordinator’s access to county mental health is good—most report to the director or to a deputy director—the coordinator provides a potential focal point for HMD services provided by all the agencies.

A second mechanism for improving coordination among providers is the holding of regular meetings with the Homeless Coordinator. Nine of the 17 counties surveyed reported holding regular meetings of providers, either alone or in the context of formal meetings of the Homeless Task Force. Counties that did not hold regular meetings tended to be the smaller ones, who may not need them to achieve good communication and coordination. Some of the counties have developed lists of all public and private agencies serving the homeless and HMD populations; the respondents who mentioned these lists noted that they have been extremely helpful in obtaining services and coordinating treatment for clients.

In addition to meetings held by the Homeless Coordinator, in some counties other broader organizations seek to coordinate services to the homeless. For instance, in Alameda County, the Emergency Services Network (ESN) holds monthly meetings bringing together a broader group of providers than the HMD contractor meetings. ESN has several committees that are responsible for considering a variety of issues and recommending approaches for the county to take. Much of the information collected by ESN in its annual shelter survey has been used by the county to plan and set priorities for expenditures on services to the homeless.

With only rare exceptions, respondents indicated that improved coordination among homeless service providers is a major benefit of the homeless program because, in addition to providing new services, it provides a central, unifying program and contact point for several formerly disjointed services. Respondents felt that improved coordination allows providers to make more efficient use of existing services, including those which are not HMD funded but were not used by homeless clients before the HMD program.

A third mechanism for interagency coordination at the individual case level is case management and case referrals between providers.

Such coordination comes about in different ways in different counties. In Yolo, for example, the outreach team and each county program director constitute a homeless support team, which deals with general program problems as well as problems associated with a specific client. The fact that each client has an associated outreach worker who remains responsible for continuity of care means that each agency—or a landlord—knows who to contact for that client. In Orange County, the fact that outreach workers have county vehicles for transporting clients to services is a critical link among service providers. The outreach team has also worked hard to establish an extensive referral network throughout the community, and it has experimented with outstationing a worker in a General Relief office to identify individuals in need of mental health care and help them process their forms. This experiment was so successful that the county would like to extend the practice to other agencies—e.g., SSI and Unemployment—likely to come in contact with the HMD. In contrast, coordination of services is not a major focus of the provider-based system in Alameda County. Many of the agencies provide the same set of services to potentially the same set of clients.
EFFECTS ON THE COMMUNITY AND ON COUNTY SERVICE AGENCIES

Overview

To this point, our discussion of the county programs has focused on measurable indicators of services delivered—characteristics of persons served, services used, and selected outcomes. Below we examine the more intangible effect of the county programs on community awareness and attitudes toward the HMD and their influence on the services provided to the HMD by mental health and social services agencies. Table 4.8 summarizes county responses to the telephone interview questions addressing these effects (see App. D for the interview protocol). Our discussion is based chiefly on interviews with the directors of the various county departments of mental health, the Homeless Coordinators, and selected agency personnel.

Community Awareness of the HMD

The 17 counties we interviewed were divided on the issue of whether their respective programs had increased community awareness of the HMD specific service needs. Among the seven counties who responded with an unequivocal yes, the most frequently mentioned examples were: creating a "forum" for discussing the problems and needs of the HMD; heightened understanding among local merchants of HMD special problems; and, in general, more acceptance of the HMD population especially through increased media coverage.

Those counties who responded in the negative did so for different reasons. They felt that the program had had no effect because it was "too new and the problem too small"; the community could still not distinguish among the various subgroups of homeless; or the county was already appropriately educated before the HMD program was implemented.

Table 4.8

EFFECTS ON COMMUNITY AND COUNTY SERVICE AGENCIES

<table>
<thead>
<tr>
<th>Effects</th>
<th>Number of Counties Responding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Increased community awareness</td>
<td>7</td>
</tr>
<tr>
<td>Increased support from Board of Supervisors</td>
<td>8</td>
</tr>
<tr>
<td>Better/more services from:</td>
<td></td>
</tr>
<tr>
<td>Mental health agencies</td>
<td>11</td>
</tr>
<tr>
<td>Social service agencies</td>
<td>8</td>
</tr>
<tr>
<td>Better police interaction with HMD</td>
<td>9</td>
</tr>
</tbody>
</table>

SOURCE: Telephone interviews with county HMD program administrators in 17 counties.
County Supervisors' Attitudes Toward the HMD

Most counties surveyed cited various indicators of positive attitudes and support for the HMD program from county supervisors. Such indicators include the establishment of board-mandated countywide task forces on the homeless, positive appraisals of the programs, increased support, "putting the HMD on the map," and identifying the HMD as a particularly needy population.

However, respondents in five counties felt that their boards endorsed the HMD programs only passively because of strong local opposition. The remaining counties perceived no difference in supervisors' attitudes after the program was implemented.

Changes in Services to the HMD by County Agencies

Two-thirds of the counties indicated that the HMD were now receiving more and better services from county mental health—especially food and shelter, new levels of care and support, increased referrals and interagency coordination, and a new awareness of substance abuse. Respondents also commented that since the implementation of the HMD program, "mental health was the only department doing anything about the homeless" and that "county mental health formed the connecting link with the HMD population that formerly had been missing."

The three counties that responded in the negative indicated that HMD providers were not connected to the traditional mental health system, or that simply there had been no change.

Less than half of the counties surveyed thought that county social service agencies had been affected by the HMD program. Positive responses chiefly focused on expanded services and better coordination with entitlement service providers, most particularly with General Assistance and SSI. Observed one respondent: "The big impact was that the agency was forced to focus on this population, and people from my program get treated differently." Another respondent commented that representative payee services were being provided for the first time.

In an equal number of counties, perceptions of changes in social service delivery to HMD varied among respondents from the same county. Positive changes ranged from establishing pilot programs with General Assistance offices to increases in referrals to entitlement programs. On the negative side, respondents commented that the time it takes to make an eligibility determination had not changed, that the nature and approach of the system remained the same, or that changes initiated by the social services agencies "had antagonized another department by uncovering new cases that qualified for local General Assistance."

Interactions with Police

A majority of counties believed that the police had come to understand the HMD better by working closely with outreach teams and participating in countywide task forces. Several respondents indicated that police referred the HMD to mental health clinics more frequently than they did in the past; others said a strong referral pattern existed before the HMD program.

Two counties indicated no change in police interaction with the HMD. Three other counties stressed clearly negative experiences, for example, a sheriff who first cited and released the homeless, then called the outreach team.
SERVICE GAPS

To identify potential unmet needs and to develop an understanding of county priorities were additional HMD funds available, we asked our county respondents to address the following two questions:

• Are there any changes you would like to see made to the HMD program?
• If your HMD allocation were increased by 50 percent, how would you spend the additional funds?

Responses to these questions overlapped remarkably. Counties generally identified the following five service areas as needing particular attention (number of counties who suggested each is in parentheses):

• Housing (13)
• Outreach (11)
• Case management (9)
• Drug/alcohol treatment (6)
• Vocational services (4)

Several other service areas frequently mentioned included mental health day treatment, drop-in shelters, and training. Two counties underscored the need for enhancing monitoring and evaluation of the program. Many of these areas will be discussed in the following section as part of our overall program assessment.

Finally, several counties indicated they would use additional funds in part to raise HMD staff salaries, and several large counties would use funds to provide a more comprehensive geographical coverage of their county.
V. DISCUSSION

Overall, we found that the HMD-funded programs implemented by the counties meet the intent of the legislature by providing new or expanded services to the homeless mentally disabled. The counties used the flexibility provided by the legislation to set service priorities and implement service delivery systems that best fitted their particular circumstances—in particular, their level of funding, the pre-existing service network, and the county’s 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 long-term housing arrangements.

In this section, we discuss these program gaps and suggest some approaches to filling them. We also discuss improving service delivery and identify some important areas for future research.

UNDERSERVED GROUPS OF HMD

The Severely Mentally Disabled Homeless

Table 5.1, drawn from our three-county survey of homeless individuals, shows that the gap between needs and service use is substantial for the homeless who are severely mentally disordered.

- 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 have no one to go to for help to get services.
- More than two out of three have a history of drug or alcohol abuse.
- 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 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.
Table 5.1
GAPS BETWEEN NEEDS AND SERVICES FOR SEVERELY MENTALLY DISORDERED HOMELESS

<table>
<thead>
<tr>
<th>Service Category</th>
<th>SMD (%)</th>
</tr>
</thead>
<tbody>
<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 to get 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</td>
<td></td>
</tr>
<tr>
<td>in last 12 months</td>
<td>7</td>
</tr>
</tbody>
</table>

The figures in Table 5.1 reflect service use by those mentally disabled persons who are currently homeless. Thus they represent only the lower bound of unmet needs. They exclude both the “at-risk” homeless and the formerly homeless mentally disabled who have been placed in permanent living situations such as transitional residential facilities and board and care. We do not have parallel information on the service needs of these groups. The figures also exclude some service needs such as vocational and rehabilitation services.

Our evidence suggests that these unmet needs could not be filled by more effective targeting on the HMD or by mobilizing underutilized service capacity. As shown in Sec. IV, HMD service providers generally target effectively on the HMD, and they are currently operating near or at capacity.

The Dual Diagnosed Homeless

Our finding that a majority of the severely mentally disabled are also substance abusers is one of the most important of this study. The problem of the HMD is not one of mental disability and homelessness; rather, it is a complex interrelationship among mental disability, substance abuse, and homelessness.

Our program staff respondents focused on four basic reasons why they were unable to deal with this more difficult issue.

1. The HMD program prohibits using funds for serving substance abusers unless the diagnosis is secondary, and does not provide funding for treatment of substance abuse.
(2) 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.

(3) Substance abuse may exacerbate a psychiatric disorder, making the individual more resistant to treatment. Indeed, effective treatment of serious mental disorder (whether the individual is homeless or not) is often not possible until after substance abuse is treated. Further, substance abuse is often associated with serious medical problems.

(4) Neither substance abuse nor mental health treatment programs are currently designed to provide the special treatment needed by the dual diagnosed.

The gap in services for the dual diagnosed HMD is a critical problem. Addressing it will require resolving complex institutional and financial questions as well as defining appropriate treatment modalities. Therefore, we suggest that the state establish a task force with the mandate to review the problem and develop specific recommendations to address it. In addition to state and county officials, the task force should include mental health and substance abuse experts. It should also include physical health experts because substance abuse is often associated with serious medical problems.

The Hard-to-Reach HMD

Another subpopulation that the program does not now serve is that small, but not insignificant, minority of HMD who cannot be readily persuaded, even after repeated attempts, to accept a managed approach to delivery of the services they need. 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 of the HMD population. 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 some who resist placements 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 (see “Alternative Housing Arrangements” below).

Most, however, and in some cases reluctantly, expressed the view that easier initiation of involuntary commitment proceedings is both desirable and necessary. They cautioned, however, that if such a measure was considered it would have to be accompanied by (1) lengthening the maximum time of the initial commitment “to allow for full stabilization of the individual” prior to release and (2) increasing the number of available hospital, crisis, and/or transitional beds. As noted earlier, nearly all counties reported a shortage of such beds.

Most program staff also noted the need to establish or expand the temporary conservatorship program to help individuals discharged from hospitals and/or transitional facilities to manage their affairs while in the community.

The At-Risk Population

A fourth subpopulation not now fully served is the mentally disabled “at risk” of homelessness. HMD-funded programs have focused their resources on serving the currently homeless, with a few exceptions: Santa Clara’s program for families with mentally disabled
members; Alameda County's Mental Health Advocates, which works with housed clients to maintain entitlement benefits; and case management efforts among the former homeless.

In part, this lack of emphasis on prevention derives from the difficulties in identifying and then tracking the "at-risk" population. They are a large and diversified population that includes:

- individuals living with relatives who may eventually exceed 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 autonomy and the sense of mastery that accompanies handling the pressures of 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 L.A. 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 contacts with the clients and those surrounding them, whether or not there is a current problem.

Although computer technology is not a substitute for direct contact with clients, it has the potential to assist case managers with coordinating a client's services from several different agencies and monitoring the status of those "at risk." For example, on-line exchanges of information about an engaged client's service needs, level of functioning, medications, social and financial resources, and living arrangement could enable a case manager to track that client along the various components of the state and county service delivery system. In the case of those at risk, on-line information exchange could encourage prevention of homelessness as opposed to after-the-fact intervention. For instance, the SSI and General Assistance administrations could regularly notify appropriate case managers if a mentally disabled client were about to lose benefits because of a failure to meet recertification requirements. The case managers could then intervene to prevent the loss, which might have resulted in homelessness.

A recent small-scale experiment in New York suggests that this kind of information exchange has great potential for enhancing service coordination problems (Vernez and Burdick, 1986). The NYC Human Resources Administration merged two data files so that its child protective services (CPS) workers are automatically notified of the impending termination of a family's welfare benefits. The CPS workers can move quickly to remedy the problem, thus averting financial stress and potential adverse effects on the children.

With appropriate procedures to protect privacy, this approach could be expanded in a few counties to include hospitals, jails, and even families with mentally disabled relatives, and could be evaluated regarding its feasibility, costs, and potential for distributing information in a noninvasive manner.
GAPS IN CONTINUITY OF CARE

Most of the severely mentally disabled require a wide range of treatment and supportive services throughout their entire life. County officials and service providers identified four basic reasons why the counties cannot provide individual HMD with this continuum of services.

- 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

Many county mental health programs, particularly in large urban counties, are already operating at capacity. The counties have been coping with this in different ways. At one extreme, the HMD-funded program may run parallel to the existing mental health system. Service providers in the two systems interact only in crisis situations such as suicide attempts or acute psychotic breakdowns that may require involuntary hospitalization. At the other extreme, where counties have tried to integrate the HMD-funded program with the county mental health system, 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. For instance, at one mental health outpatient clinic serving the homeless, those with schizophrenia and bipolar affective disorder are served to the exclusion of all other mentally disabled.

Alternative Housing Arrangements

A particularly large gap in the continuum of care is the lack of specialized housing alternatives for the mentally disabled. The nature of chronic mental illness limits the ability of these individuals to live completely independently. But 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. Yet the available residential alternatives offer a stark choice between entirely independent living and group residential facilities that typically enforce many rules. Many staff suggested a need for additional alternative housing arrangements. In most cases, the arrangement they suggested was independent apartment-style living with a built-in support system designed to provide crisis assistance, help with money management, ongoing access to mental health day treatment and medications, and socialization and rehabilitation services.

Although still largely untested, this residential arrangement may have several advantages over the traditional residential and board-and-care facilities: (1) Individuals may find it more acceptable because it offers greater self-reliance and privacy; (2) relative to board and care, it is more flexible because it offers more intensive support services on an as-needed basis; and (3) it could be dispersed throughout the county, thus minimizing the negative community reactions stimulated by a concentration of housing for the mentally disabled.
Entitlement Benefits

Although a number of entitlement benefits are available for the mentally disabled, our study found that most of the homeless with severe mental disorders were not currently receiving them (see Table 5.1). For example, most of the severely mentally disordered should be eligible for SSI because their chronic mental disorder probably prevents them from holding a job over a sustained period. However, our survey indicates that only 12 percent receive it. Our survey also indicates that about 20 percent of the HMD are veterans and thus may be eligible for pensions and health benefits through the Veterans' Administration, although only 3 percent receive them.

Securing and maintaining entitlement benefits are the keys to accessing the services needed to stabilize the mentally disabled in the community. Currently, the major sources of income support are:

- **Supplemental Security Income (SSI)** which provides monthly cash payments to individuals who are unable to sustain “substantial gainful activity” because of a physical or mental impairment. Individuals eligible for SSI are automatically eligible for Medi-Cal.

- **Social Security Disability Insurance (SSDI)** which replaces earnings lost because of a physical or mental impairment that prevents an individual from working for a period of at least one year. The monthly amount is based on the income earned by the individual prior to onset of the disability. Individuals receiving SSDI payments are also eligible for Medicare.

- **General Assistance (GA)** which provides a monthly cash payment for individuals whose income falls below a threshold established by the county. In most counties, if an individual who applies for GA appears to meet the eligibility requirements for SSI, he/she will be required to apply for SSI as a condition of receiving GA.

- **Veterans' Administration pensions** which are available for individuals who have served during wartime for 90 days or more and are permanently and totally disabled. Individuals who have served in the armed forces also have access to Veterans' Administration health care delivery systems, which include inpatient and outpatient mental health services.

Obtaining eligibility for most of the programs is both complex and time consuming. Most require completing lengthy forms (the GA form in one county we visited was 32 pages long) and providing extensive supporting documentation. In the case of SSI and SSDI this includes a health professional's certification that the individual has a mental disorder sufficient to prevent him/her from holding a job.

Several of the counties have tried innovative approaches to assisting individuals with the process of applying for entitlement benefits. For example, Orange County outstationed a mental health worker in a General Assistance office to educate the staff to identify and work with mentally disordered individuals and to help the staff become an effective referral source to county mental health. The project substantially increased the number of mentally disabled individuals identified and referred to county mental health. Although the project lasted only a month, the educational efforts had long-term effects because the level of referrals has been maintained.

Other county attempts to help individuals apply for entitlement benefits include making special arrangements with the local SSI office and funding an advocacy group. Several counties have expressed the need to expand these kinds of activities.
Although most of the HMD-funded programs seek to assist individuals in applying for entitlement benefits, we were unable to obtain data from the programs or the counties indicating the number of individuals that had successfully obtained such benefits. The necessity of these benefits for breaking the cycle of homelessness as well as the importance of this information for evaluating programs suggest that the counties should devote greater efforts to collecting these data.

Once mentally disabled persons secure eligibility, they may need continuing help in maintaining it. For example, in the first year of SSI eligibility, recertification is frequently required. This may demand that the individual undergo yet another mental status examination by a health professional, answer questions about activities undertaken since benefits were extended, and appear at a recertification hearing. Failure to respond to these requests can result in the loss of benefits, breaking the stream of income and potentially causing housing dislocation.

One type of program that has been successful in preventing the initiation of this cycle is money management. Under this program, all benefits-related mail is received by the money manager, who has the authority to open the correspondence and work with the individual to respond to various requests. This program provides a support system that is already in place should a crisis arise. Most of the staff we interviewed in money management programs indicated that they were very successful in maintaining ongoing contacts with clients and preventing problems from escalating to the crisis stage.

Case Management

Individuals with chronic and severe mental disorder may require assistance that will vary with the individual 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. Continuity in support services can offer these individuals relief from painful and disabling symptoms, assistance in everyday functioning, improved quality of life, and potential reductions in the number and intensity of acute episodes of illness and homelessness.

At best, the county HMD-funded programs provided limited continuity of case management because of the difficulties inherent in serving a mobile, unstable, and chronically ill population and because of resource constraints. As we noted in Sec. IV, growing caseload may cause counties to choose between providing continuity (giving each client a "permanent" case manager) and reaching new clients. County staff indicated that if additional funds were available, expanding case management would have priority second only to housing.

Still, we believe that an expansion of case management in the HMD program might have limited impact and might not address several complementary issues. First, the pay for outreach/case managers staff is low and attrition high as reported by some counties. Second, this staff has limited training and experience (see "Training" below). If case management is to be expanded, these issues would have to be addressed, as would the need to develop better techniques for client tracking and follow-up. As we noted above, a promising approach to improving tracking is the development of an on-line interactive system.
IMPROVING SERVICE DELIVERY

Perhaps the most important step in improving the 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 in the areas of outreach, training, and community education and involvement.

Program Goals

The goals of the HMD program were defined differently by different members of the county program staff. The definitions ranged from "providing basic subsistence services to the HMD" and "getting the HMD off the street" to "secure, stabilize, and maintain the HMD in safe and adequate living arrangements in the community." The different priorities and institutional arrangements adopted by the various counties clearly indicate that not all counties—and not all providers within counties—have the same program goal in mind.

Although a certain diversity is to be expected from staff who are articulating their own perspectives, clarifying the ultimate goals of the program is critical for several reasons:

First, common goals are essential for evaluating program outcomes. For example, is the success of the program to be evaluated by the number of individuals receiving subsistence services, by the number of persons placed and maintained in permanent living arrangements in the community, or by the number of clients accepting mental health treatment? 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.

Second, common goals are essential for designing more appropriate reporting requirements; reporting is most useful to management when it derives logically from the goals. Put another way, reporting underlines to staff what is expected of them and gives the program administrators a way to monitor staff efforts against explicit standards. Current requirements emphasize subsistence and mental health services provided with HMD funds. Excluded are such measures as engagement rates by outreach teams, use of non-HMD-funded mental health services (regardless of other funding source), obtaining and maintaining entitlement benefits for HMD clients, and placement of the HMD in housing arrangements other than board and care. The absence of these measures 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; (2) clearly link the requirements to the goals of the program. For example, if a major goal of the program is to place and maintain individuals in housing arrangements in the community, reporting should include an unduplicated count of individuals placed in various types of housing. If a complementary goal is to move clients along the continuum of care, reporting could include appropriate intermediate measures of outcome, such as those noted earlier.

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

Many homeless mentally disabled persons are not now in HMD-funded programs. Some of them might be engaged if outreach efforts were more responsive to the routines and patterns of the HMD.

Outreach to the HMD in the county programs we have seen takes place primarily through (1) referrals from the community and providers of services, and (2) outstationing of workers at shelters or other service facilities or on the street. 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 outstationing. This raises issues of whether the more independent HMD and the more severely mentally disabled are being reached.

A related issue is flexibility of scheduling. Many of the 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. The difficulty with "off hours" is that other service providers (e.g., benefit agencies, mental health clinics) may not be available during those times; thus, a follow-up contact would be required to link the individual to services.

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 are likely to come in contact with the HMD, are sensitized to the special needs of the population, are made aware of the programs available to the HMD, and are trained in effective referral techniques. Physical health clinics do not appear to be involved in the agency-to-agency referral network in many counties, although our survey showed that more than half of the HMD had visited such providers in the six months preceding the interview. We recommend including them 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 meetings of providers called by the Homeless Coordinators, some of whom have moved to fill in 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 and counseling)
- Assessment of client needs

Community Education and Involvement

The counties' ability to serve the homeless continues to be limited by the difficulties encountered 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 we interviewed 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. The programs have also encouraged the establishment of local task forces on the homeless. 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 study 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. Occasionally, alternative estimation methods in a single county resulted in dramatically different estimates: For example, one county estimated having a range of 550 to 15,000 HMD.

In allocating HMD funds to the counties, the State Department of Mental Health did not use these "unreliable" estimates. Instead, allocation was 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 on 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 allocations of HMD funds to these counties, 4.9, 5.0, and 0.5 percent, respectively, are roughly proportional to our estimates of the HMD population sizes in these counties: Alameda and Orange counties have similar HMD population sizes; Yolo County has an HMD population that is about one-tenth that of Alameda or Orange.

This finding does not imply that the remaining allocations across counties would also be proportional to their HMD population sizes. 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 our own and (2) to examine the correlation of the funds allocated to the sizes of the HMD populations found. We believe that the enumeration method we used in this study could be used in other counties, at fairly low cost.\(^1\) Although it has a number of limitations, it provides an objective and standardized yardstick against which the state could gauge the relative size of homeless populations across service areas.

\(^1\)We estimate that the enumeration would cost between $7,000 and $15,000, depending on the size of the county. Mental health screening would not be required because rates of severe mental disorder among the homeless show little variation across counties.
Effectiveness of Alternative Service Organizations

As seen in Sec. IV, counties vary widely in their approaches to serving individual clients, in their reliance on contracted services, in the nature and level of their outreach activities, and in the extent to which their HMD-funded programs are integrated with their department of mental health service system.

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 (see "Program Goals" above) and following selected HMD over time in a number of counties varying 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 of the homeless in three California counties was that persons who become homeless at some time during a year outnumber by 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. In estimating the annual prevalence of homelessness, we assumed that the total homeless population is stable and changes little in size over the course of a year (see Table 3.2). But 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?
- If the number of "new" HMD is increasing over time, what factors are driving the increase?
- Can preventive programs be launched 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 consent to involving them. 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 which is 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. Evidence suggests that such family interventions can reduce the cost of care by decreasing the need for inpatient treatment. 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?
Appendix A

SELECTION OF 17 SAMPLED COUNTIES

We selected 17 from the 56 California counties participating in the HMD program for the telephone interview component of the study. (Alpine and Siskiyou elected not to participate in the HMD program.) These counties were to vary in:

- Population size, density, ethnic composition, and size of the HMD allocation relative to total budget for mental health
- HMD programmatic approaches and emphases
- Service priorities
- Institutional arrangements for delivery of services to the HMD.

To aid in this selection, we grouped the 56 counties into ten fairly homogeneous clusters, after selecting a priori the four counties with the largest allocation of HMD funds: Los Angeles, San Diego, San Francisco, and Orange counties. Each cluster contained counties that were similar with respect to the factors listed above. We then selected one or two counties from each cluster in consultation with a representative of the State Department of Mental Health.

FACTORS USED TO FORM CLUSTERS OF COUNTIES

In selecting the 17 counties, many criteria were considered important; therefore, cluster analysis was used to combine similar counties into groupings from which we could select the counties for this study.¹ No attempt was made to find optimal clusterings, but only to develop intuitively reasonable groupings that made the county selection more tractable.

¹In cases where items are characterized by only a few attributes, groupings can be readily identified by visual inspection. As the number of pertinent attributes increases, groupings can no longer be readily ascertained. Cluster analysis is a valuable technique for forming groupings of items described by many attributes.
The discussion that follows describes the variables and algorithm used in the cluster analysis and the results of that analysis.

VARIABLES USED TO FORM CLUSTERS OF COUNTIES

The variables used for forming groupings of counties are listed in Table A.1. The first set of variables describes the demographics or physical aspects of the county itself. The second set describes county mental health budget information. The final set describes proposed plans for the county's program. These latter variables were derived from the applications submitted to the state by each county.

Because the variables in Table A.1 do not share a common metric, each of the variables was standardized to have a mean of zero and a variance of one. Therefore, a variable such as the HMD allocation which ranges well over $1 million will not overly influence the results of the cluster analysis when combined with variables that take on only the values of zero or one. At the time of the selection of the counties, proposals by seven counties (El Dorado, Lake, Modoc, Plumas, Shasta, Sutter, and Yuba) were not available to us. Because of this, we excluded these counties from the cluster analysis.

THE CLUSTER ALGORITHM

We used the cluster algorithm (PROC CLUSTER) provided in the Statistical Analysis System (SAS) programming package. This algorithm uses Ward's method for determining a hierarchy of clusters. The method begins by considering each item as a separate cluster. Then all possible clusters of two items are formed, and a sum of squared deviations from the cluster's mean are computed. The cluster with the smallest sum of squared deviations is taken. This procedure continues up the hierarchy until eventually all items are combined into a single cluster (Everitt, 1980).

Once the complete hierarchy is formed, one must determine what level of the hierarchy to examine. For our analysis, we chose to examine ten clusters of counties. Ten provided sufficient reduction of information to make selection tenable, but was not so few that the groupings no longer seemed reasonable.
### Table A.1

**VARIABLES USED TO CLUSTER CALIFORNIA COUNTIES**

**First set**

1. **DENSITY**  
   Ratio of the county's population (1986) to its land area (in sq. miles).

2. **REGIONS**
   - **REG1**  
     Northern California (includes Del Norte, Siskiyou, Modoc, Humboldt, Trinity, Shasta, Lassen, Mendocino, Tehama, Plumas, Butte, Glenn, Colusa, and Lake).
   - **REG2**  
   - **REG3**  
     Central and Eastern California (includes Sierra, Nevada, Placer, El Dorado, Yuba, Sutter, Yolo, Sacramento, San Joaquin, Stanislaus, Merced, Amador, Calaveras, Tuolumne, Alpine, Mariposa, Madera, Fresno, Kings, Tulare, Kern, Mono, and Inyo).
   - **REG4**  
     Central and Western California (includes San Benito, Santa Cruz, Monterey, San Luis Obispo, Santa Barbara, and Ventura).

**Second set**

3. **MINPROP**  
   The count of blacks and Hispanics in the county divided by the total population.

4. **MINTEMP**  
   Average annual minimum temperature in the county.

5. **HALLOC**  
   HMD funds allocation in dollars (from department of mental health).

6. **HTPROP**  
   Ratio of HMD allocation to total mental health budget.

**Third set**

6. **OUT1**  
   Proposal to perform direct outreach.

7. **DIRECT**  
   Proposal to provide some services directly by the county's department of mental health.

8. **CONTRT**  
   Proposal to contract out some services to independent service providers.

9. **ATRISK**  
   Proposal to put greater emphasis on those "at risk" of homelessness.

10. **HOMLESS**  
    Proposal to focus on the "homeless" population over the "at-risk" population.

11. **BSHELTER**  
    Proposal to provide short-term residence (less than a month).

12. **LSHELTER**  
    Proposal to provide long-term residence (over a month).

13. **COMMUN**  
    Community involvement in either the planning or implementation stage.

14. **SUBPOP**  
    Proposal to target a specific subpopulation (e.g., youth, elderly).

### Table A.2

**CLUSTERING CHARACTERISTICS BY COUNTY**


**NOTE:** See Table A.1 for description of column labels.
GROUPINGS OF COUNTIES

Table A.2 shows the results of the cluster analysis. The variable SELECT indicates those counties that were eventually selected for the study. The variable CLUSTER indicates which counties were combined into each of the ten clusters. The number of the cluster is arbitrary.
Appendix B

QUESTIONNAIRE FOR SURVEY OF THE HOMELESS
Now I have some questions about your physical and mental health and your use of programs and services. It will take about 20 or 25 minutes. When we've finished, I'll pay you $3 for your time.

(As I explained earlier, this is a survey on housing in this county. We're asking about 100 people the same questions. The survey will help the state and county improve services for people who sometimes don't have regular homes.)

You don't have to take part in this survey and can refuse to answer a question, or stop the interview at any time. Remember, we won't ask your name, and nothing you tell us can be associated with you personally.
I. HISTORY OF HOMELESSNESS

First are some questions about your living arrangements.

1. When was the last time you had a home for at least 30 continuous days? By home, I mean having your own room, apartment, or house, living in a home with family, friends, or caretakers; or staying in a hospital, treatment facility, or board and care home.

   WRITE IN MONTH AND YEAR:  
   
   (IF Q.1 IS PRIOR TO 12 MONTHS AGO, GO TO Q.2)

1A. Did you have a home every night between (CURRENT MONTH) 1986 and (MONTH AND YEAR IN Q.1), or were there times during that period when you were homeless?

   CONTINUOUSLY HAD HOME ............... 1  --> (GO TO Q.2)  
   OTHER TIMES HOMELESS ............... 2

1B. How many different times between (CURRENT MONTH) 1986 and (MONTH AND YEAR IN Q.1) were you homeless or without a regular place to live?

   WRITE IN # OF TIMES:

2. During the past 30 days, how many nights did you sleep or rest.

   NUMBER OF NIGHTS

   a. In a shelter or mission? ...........................................................  
   
   b. In a rented room? .................................................................  
   
   c. On the streets, in a park or campground, or, in an empty or abandoned building?  
   
   d. In a public place like a bus, bus station, all night movie, airport or bar? ...........  
   
   e. In a relative's or friend's home or apartment?  
   
   f. In a car, truck or van? .........................................................  
   
   g. In jail? ....................................................................................  
   
   h. Somewhere else? .................................................................  

   WHERE?

   (IF R SPENT ONE OR MORE NIGHTS IN A SHELTER OR MISSION [Q.2a = 1 OR MORE], GO TO Q.4.)
3. If you could stay in a shelter or mission, would you want to?

YES .......................... 1
NO .......................... 2

4. During the past 30 days, was getting enough to eat usually, sometimes, rarely, or never a problem for you?

USUALLY ............ 1
SOMETIMES .......... 2
RARELY ............... 3
NEVER ............... 4

5. During the past 30 days, where have you gotten your meals most often?

MARKET OR PREPARED AT HOME ...... 1
PAID MEAL AT COFFEE SHOP/ RESTAURANT ........................................ 2
MISSION, SHELTER OR SOUP LINE ...... 3
FRIENDS OR RELATIVES ............... 4
HANDOUT ........................................ 5
FOOD FOUND ON STREETS ............. 6
INSTITUTION (JAIL/TREATMENT FACILITY) ........................................ 7
OTHER ........................................ 8
SPECIFY: ________________________
II. MENTAL HEALTH

These next questions are about how things have been with you lately.

6. In your lifetime, have you ever had two weeks or more during which you felt sad, blue, depressed, or when you lost all interest and pleasure in things that you usually cared about or enjoyed?

   YES ........................................ 1
   NO ........................................ 2 ---> (GO TO Q.7, NEXT PAGE)

   YES   NO
   A. Has there ever been a period of two weeks or longer when you lost your appetite? ................................................................. 1 2 37/
   B. Have you ever had a period of two weeks or more when you had trouble falling asleep, staying asleep, or waking up too early? ... 1 2 38/
   C. Has there ever been a period lasting two weeks or more when you felt tired out all the time? ...................................................... 1 2 39/
   D. Has there ever been a period of two weeks or more when you had to be moving all the time—that is, you couldn’t sit still and paced up and down? ................................................................. 1 2 40/
   E. Was there ever a period of several weeks when your interest in sex was a lot less than usual? ...................................................... 1 2 41/
   F. Has there ever been a period of two weeks or more when you had a lot more trouble concentrating than is normal for you? .......... 1 2 42/
   G. Has there ever been a period of two weeks or more when you felt worthless, sinful, or guilty? ...................................................... 1 2 43/
   H. Has there ever been a period of two weeks or more when you thought a lot about death—either your own, someone else’s, or death in general? ................................................................. 1 2 44/
7. Have you more than once had the experience of hearing things other people couldn't hear, such as a voice?
   7A. What did you hear?

8. Have you ever had the experience of seeing something or someone that others who were present could not see -- that is, had a vision when you were completely awake?
   8A. What did you see?

9. Have you ever believed people were watching you or spying on you?
   9A. Could you give me an example of when (UNDERLINED ABOVE)?

10. Have you ever believed you could actually hear what another person was thinking, even though he was not speaking, or believed that others could hear your thoughts?
    10A. How did they do that?
11. Have you ever had unusual feelings inside or on your body -- like being touched when nothing was there or feeling something moving inside your body?
   11A. What did you feel?

12. Have you ever believed that someone was plotting against you or trying to hurt you?
   12A. Could you give me an example of when (UNDERLINED ABOVE)?

13. Was there ever a time when you believed people were following you?
   13A. How did you know that (UNDERLINED ABOVE)?

14. Have you ever felt that someone or something could put strange thoughts directly into your mind or could take or steal your thoughts out of your mind?
   14A. Could you give me an example of when you felt that (UNDERLINED ABOVE)?

15. If you were to add up all the periods of time when you've had this (belief/experience) or any serious difficulty with emotional or mental problems, would this add up to as much as six months?
   YES .................. 1
   NO ..................... 2

CARD 01
16. Did you ever think that you were an excessive drinker?

YES .......................... 1
NO .......................... 2

17. Have you ever drunk as much as a fifth of liquor in one day? That would be about 20 drinks, or 3 bottles of wine or as much as 3 six-packs of beer in one day.

YES ........................................ 1
YES (VOLUNTEERS ONLY ONCE) .......... 2
NO ........................................... 3

18. Has there ever been a period of two weeks when every day you were drinking 7 or more beers, 7 or more drinks or 7 or more glasses of wine?

YES ............................ 1
NO ............................ 2

19. (SHOW BUT DO NOT HAND CARD 1) Here is a list of drugs. Have you ever used one of these drugs on your own more than 5 times in your life? By "on your own", I mean to get high or without a prescription, or more than was prescribed. Would you like me to read the list, or would you rather read it yourself? (READ LIST OR HAND CARD TO R)

CARD 1

YES ............................ 1
NO ............................ 2  --> (GO TO Q.22)

20. Did you ever find you needed larger amounts of these drugs to get an effect -- or that you could no longer get high on the amount you used to use?

YES ............................ 1  --> (GO TO Q.22)
NO ............................ 2

21. Did you ever have any emotional or psychological problems from using drugs -- like feeling crazy or paranoid or depressed or uninterested in things?

YES ............................ 1
NO ............................ 2

CARD 01
III. HEALTH CARE

Next are some questions about your health.

22. At the present time, would you say your health is excellent, good, fair, or poor?

EXCELLENT ........ 1
GOOD ............... 2
FAIR ............... 3
POOR ............... 4

23. Which of the following are you able to do for yourself completely? Are you able to........ by yourself, or do you need help? (REPEAT STEM AS NEEDED.)

<table>
<thead>
<tr>
<th>DO YOURSELF</th>
<th>NEED HELP</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Buy a bus ticket? ....................... 1</td>
<td>2</td>
<td>3 61/</td>
</tr>
<tr>
<td>b. Get help at an emergency room? ........ 1</td>
<td>2</td>
<td>3 62/</td>
</tr>
<tr>
<td>c. Find a phone number you need? .......... 1</td>
<td>2</td>
<td>3 63/</td>
</tr>
<tr>
<td>d. Take medications as prescribed by the doctor? ........................................ 1</td>
<td>2</td>
<td>3 64/</td>
</tr>
<tr>
<td>e. Fill out an application for benefits, like disability income, food stamps or general relief? ........................................ 1</td>
<td>2</td>
<td>3 65/</td>
</tr>
</tbody>
</table>

24. Have you ever stayed overnight in a hospital or treatment program for problems with alcohol or drugs?

YES ................... 1 66/

NO ................... 2 --- (GO TO Q.25)

24A. In the past 12 months, did you stay overnight in a hospital or treatment program for problems with alcohol or drugs?

YES ................... 1 67/

NO ................... 2

25. (Not counting overnight stays), did you visit a doctor or mental health specialist for problems with alcohol or drugs in the past 6 months?

YES ................... 1 68/

NO ................... 2
26. These next questions are about emotional or mental problems, not counting problems with alcohol or drugs. Have you ever stayed overnight in a hospital or treatment program for emotional or mental problems?

YES .................. 1
NO ..................... 2  --> (GO TO Q.27)

26A. In the past 12 months, did you stay overnight in a hospital or treatment program for emotional or mental problem?

YES .................. 1
NO ..................... 2  70/

27. (Not counting overnight stays), did you visit a doctor or mental health specialist for emotional or mental problems in the past 6 months?

YES .................. 1
NO ..................... 2  71/

28. In the past 6 months, did you take any prescribed medications for emotional or mental problems, like depression, anxiety, or trouble sleeping?

YES .................. 1
NO ..................... 2  72/

29. Now I want to ask about physical health problems, not counting emotional or mental problems or problems with alcohol or drugs. Did you visit a doctor, health professional, or clinic for physical health problems in the past 6 months? Do not include overnight hospital stays.

YES .................. 1
NO ..................... 2  73/
IV. SOCIAL SUPPORT

Next are some questions about the kinds of support you have ...

30. Do you have any relatives that you visit, talk to, or write to at least once every two or three months?

   YES ................................ 1
   NO .................................. 2

31. Do you have a legal conservator or guardian?

   YES .................................. 1
   NO .................................. 2

32. In the last 30 days, did anyone from a program or clinic:

   YES  NO

   a. Help you find a place to sleep, a meal, clothes, or a place to clean up? ...... 1 2 10/

   b. Help you get health or mental health care, like setting up an appointment or taking you to a clinic? .................................................. 1 2

   c. Help you apply for benefits like SSI, Medicare, Medi-Cal, VA benefits, general relief, or foodstamps? ................................................................. 1 2 12/

   d. Help you take care of or manage your money? .................................................. 1 2 13/

   e. Help you with anything else?
      SPECIFY: __________________________________________________________________ 1 2 14/

33. (IF YES TO ANY OF 32 a-e, ASK:)

   Who helped you? (RECORD NAME(S) OF PROGRAM(S) AND/OR PERSON(S) FOR UP TO 3)

   1. ____________________________________________________________________________

   2. ____________________________________________________________________________

   3. ____________________________________________________________________________

34. (IF NO TO ALL OF 32 a-e, ASK:)

   Did anyone from a program or clinic offer to help you out with things like that, but you didn't want help?

   YES .................................. 1
   NO .................................. 2
35. Do you have someone you can go to when you need some kind of help with things like finding a place to sleep, getting to a health clinic or taking you where you need to go?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>(\rightarrow) (GO TO Q.36)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>16/</td>
</tr>
</tbody>
</table>

35A. Who do you rely on most often?

<table>
<thead>
<tr>
<th>SOMEONE FROM A PROGRAM</th>
<th>PROGRAM:</th>
<th>(\rightarrow) SPECIFY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>17/</td>
</tr>
</tbody>
</table>

LEGAL CONSERVATOR/GUARDIAN

<table>
<thead>
<tr>
<th>RELATIVE/FRIEND</th>
<th>SOMEONE ELSE</th>
<th>(\rightarrow)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

36. In the past 30 days, have you stayed overnight at any of these places?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| a. Leisure Towers IV (in Orange on Vine) | 1 | 2 | 18/ |
| b. Jerry Mc Gee's Place (in Orange on Drew Way) | 1 | 2 | 19/ |
| c. Martha House (in Orange on Glassell) | 1 | 2 | 20/ |
| d. YWCA Hotel for Women (in Santa Ana on Broadway) | 1 | 2 | 21/ |
| e. YMCA (in Santa Ana on Civic Center Drive) | 1 | 2 | 22/ |
| f. Dailey McIntosh Center, also known as the Hearth Program (in Garden Grove on West St.) | 1 | 2 | 23/ |
| g. Shelter for the Homeless (in Midway City on Darwin St.) | 1 | 2 | 24/ |
| h. Shelter for the Homeless (in Westminster on Sherwood St.) | 1 | 2 | 25/ |

37. In the past 30 days, have you gone to the Drop-In Center in San Clemente just to hang out?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

38. Now, I'd like to ask you about programs that train people for jobs or teach them better ways to manage on their own.

Would you like to participate in a program like that?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
V. PERSONAL INFORMATION

Finally, I have just a few questions about you.

39. Are you presently married, or are you widowed, separated, divorced, or have you never been married?

MARRIED ........................................ 1
WIDOWED ........................................ 2
SEPARATED ...................................... 3
DIVORCED ...................................... 4
NEVER MARRIED .............................. 5

40. Did you ever serve on active duty in the Armed Forces of the United States?

YES .............................................. 1
NO .............................................. 2  --> (GO TO Q.41)

40A. Are you a Vietnam veteran?

YES .............................................. 1
NO .............................................. 2

41. Which of these best describes your racial background ...

1. Hispanic, ...................................... 1
2. White - (not Hispanic), ...................... 2
3. Black - (not Hispanic), ...................... 3
4. American Indian, ............................ 4
5. Asian, ........................................ 5
6. Or some other racial background? ... 6
   What?: ........................................

42. When was the last time you worked for pay, or went to school full-time (or were a full-time housewife)? (IF YEARS, MULTIPLY BY 12 TO GET NUMBER OF MONTHS.)

WRITE IN # OF MONTHS AGO:  

NEVER  --> (ENTER 996 ABOVE)

CURRENTLY WORKING/
IN SCHOOL/HOUSEWIFE --> (ENTER 000 ABOVE)

43. When was the last time you held the same job for at least 6 months?

WRITE IN # OF MONTHS AGO:  

NEVER  --> (ENTER 996 ABOVE AND GO TO Q.45)

CURRENTLY HAVE HELD SAME JOB FOR OVER 6 MONTHS--> (ENTER 000 ABOVE)
44. What is/was your job? (Is/Was that work in a sheltered workshop?)

JOB: .................................................................

SHELTERED WORK .................................................. 1 18/

UNSKilled LABORER (JANITOR, STOCK-CLERK, ASSEMBLY-LINE WORK) .... 2

SEMI-SKILLED LABORER (TRUCK DRIVER, SECURITY GUARD, SALES CLERK
GARDENER, COOK, CONSTRUCTION WORKER, COMPUTER OPERATOR) .... 3

SKILLED LABORER OR LOW-LEVEL MANAGEMENT (CARPENTER, PLUMBER
PHOTOGRAPHER, SUPERVISOR OF SEMI-SKILLED LABORERS, COMPUTER
PROGRAMMER, CHEF) .............................................. 4

MID-LEVEL MANAGEMENT OR LESSER PROFESSIONAL (NURSE, SOCIAL
WORKER, LOAN OFFICER, SMALL BUSINESS OWNER) .................. 5

TOP LEVEL MANAGEMENT OR MAJOR PROFESSIONAL (OWNER OF MID-SIZE
OR LARGE BUSINESS, POSITION REQUIRING DOCTORATE, EXECUTIVE
OFFICER OF CORPORATION) ....................................... 6

45. I'm going to read a list of benefits some people receive. Are you now receiving:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. SSI or SSDI? .................................................. 1 2 19/</td>
<td></td>
</tr>
<tr>
<td>b. Social Security other than disability? .................................. 1 2 20/</td>
<td></td>
</tr>
<tr>
<td>c. VA benefits? .................................................. 1 2 21/</td>
<td></td>
</tr>
<tr>
<td>d. Food stamps .................................................. 1 2 22/</td>
<td></td>
</tr>
<tr>
<td>e. Welfare, such as general relief or AFDC? .................................. 1 2 23/</td>
<td></td>
</tr>
<tr>
<td>f. Medi-Cal or Medicare? .......................................... 1 2 24/</td>
<td></td>
</tr>
</tbody>
</table>

END: That's all the questions I have. Thank you very much for your time and help. Good Night!

A. PAY R $3

B. CODE INTERVIEWER OBSERVATION SECTION BELOW
VI. INTERVIEWER OBSERVATION

46. DID R SEEM INTOXICATED OR HIGH?

YES ...................... 1  
NO ...................... 2  
DON'T KNOW ...... 3

47. DID R HAVE:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>TROUBLE SEEING OR HEARING?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b</td>
<td>RECENT TRAUMA (BURNS, CUTS, BRUISES)?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c</td>
<td>MISSING LIMBS OR DIGITS?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>d</td>
<td>SLURRED SPEECH?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>e</td>
<td>OPEN SORE ON MOUTH OR SKIN?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>f</td>
<td>SWOLLEN FEET OR ANKLES?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>g</td>
<td>TROUBLE WALKING OR MOVING?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>h</td>
<td>OTHER MAJOR PHYSICAL IMPAIRMENT?</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

SPECIFY: ______________________

48. DESCRIBE R'S APPEARANCE AND PHYSICAL CONDITION:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>DIRTY OR DISHEVELED</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>b</td>
<td>INAPPROPRIATE DRESS FOR SEASON</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>c</td>
<td>INAPPROPRIATE DRESS FOR SEX</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>d</td>
<td>BODY ODOR</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>e</td>
<td>OUTLANDISH DRESS</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>f</td>
<td>OTHER</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

SPECIFY: ______________________
49. HOW WOULD YOU RATE R’S GLOBAL SOCIAL SKILLS?

a. GOOD SKILLS; VERY EFFECTIVE COMMUNICATOR ........................................... 1

Good eye contact, appropriate facial expressions, good voice tone, may use gestures to complement speech, speech content organized, to the point, and easy to understand.

This individual could probably readily engage others. Understanding his/her communication requires little or no focused effort on the part of the observer.

b. ADEQUATE SKILLS; FAIR COMMUNICATOR .................................................. 2

Overall this person has adequate skills and organized speech; he can communicate adequately and make himself understood. He/she, however, exhibits deficits in one, or maybe two, skill areas (such as poor eye contact and very soft voice tone, speech may be somewhat rambling at times, face may remain generally expressionless and subject may use few facial or body gestures) that prevent him/her from being a very effective communicator.

This individual could engage others with some effort on his/her part. Understanding his/her communication requires some minimal effort on the part of the observer.

c. POOR SKILLS; IMPAIRED COMMUNICATOR .................................................. 3

Displays a combination of several deficits, such as no eye contact, persistently flat facial expression, and inaudible voice, or rambling, difficult to follow speech. Gestures may be absent or bizarre and inappropriate to speech.

This individual would have difficulty engaging others. Observers would have to exert considerable effort in order to understand him/her, but some basic communication is still possible.

d. VERY POOR SKILLS; SEVERELY IMPAIRED COMMUNICATOR .......................... 4

Shows deficits in almost all areas, such as no eye contact, voice inaudible or far too loud, gestures and body postures may be very unusual or very bizarre, or absent altogether. Speech is extremely difficult to follow (if it can be followed at all), and may be unusual in content or off the subject entirely.

This person cannot communicate with others in such a way that he/she could make himself understood, even when others exert effort to understand the communication.
50. HOW WOULD YOU RATE RS COOPERATIVENESS DURING THE INTERVIEW?

51A. WHAT WERE THE REASONS FOR RS LACK OF UNDERSTANDING?

1. MODERATE UNDERSTANDING
2. GOOD UNDERSTANDING
3. VERY GOOD UNDERSTANDING
4. LITTLE OR NO UNDERSTANDING

[GO TO Q52, NEXT PAGE]

51B. USE OF ALCOHOL/DRUGS

1. MODERATELY COOPERATIVE
2. SOMEWHAT COOPERATIVE
3. NOT VERY COOPERATIVE
4. DON'T KNOW

SPECIFY OTHER PROBLEM WITH READING

DON'T KNOW
52. BRIEFLY DESCRIBE ANY OTHER THINGS ABOUT R THAT YOU OBSERVED (FOR EXAMPLE, BIZARRE BEHAVIOR, OR BIASED RESPONSES):

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

53. RECORD TIME ENDED: [ ] : [ ] am / pm
Appendix C

GUIDELINES FOR CASE STUDIES
GUIDELINES FOR ON-SITE VISITS TO HMD PROGRAMS

The primary purpose of the program face-to-face interviews and on-site observations of program activities is to develop an in-depth understanding of how, and with what level of success HMDs are served in Orange, Alameda, Yolo, and L.A. Skid Row by the HMD program and the "regular" mental health and social services delivery system.

The on-site visits should complement and take one step further the knowledge developed in the telephone interviews. Thus, before going to the sites, you should become thoroughly knowledgeable about each of the county's context and programmatic approach.

The unit of observation for the case studies is "the program and activities within it," including the following:

PROGRAMS
- Outreach
- Case management
- Shelter
- Socialization/drop-in center
- Mental health (HMD & non-HMD)
- Others (specific for each county)

ACTIVITIES
- Outreach
- Screening/Intake
- Needs assessment
- Service plan
- Case management
- Follow-up/monitoring
- Referrals to other programs
- Services

Within each program, you will talk to and observe staff engaged in the various specific activities of the program.

In selecting staff to talk to and observe, give preference to staff who actually deliver the main services to HMDs or otherwise are in direct contact with them and to staff you have not interviewed by telephone. Although it may be appropriate to deal with a main staff person at the program, you should also talk to other staff, most particularly if they are responsible for specific subactivities (e.g., intake, case management, etc.).

In addition to the above, you should interview individuals who may be working with or contribute to the effectiveness of the HMD program staff including General Assistance, SSI, housing, police, and jail
representatives. You will determine who should be included separately for each county based on your knowledge about the relative importance of these service providers.

Draft outlines for use with each program are included as Guidelines A through E. Each program has four instruments:

A. A set of questions about the program location, capacity, maintenance, and appearance. This is the same for all.
B. A set of questions about program intent to ask prior to actual field service delivery observation. This is the same for all.
C. A set of items and events to cover and observe, inquire about, record during your observations of activities and discussions with staff.
   C.1 covers outreach activities
   C.2 all other HMD and non-HMD mental health.

After you have completed your observations, you should go back through them with the respondent to obtain a sense of the extent to which what was actually observed is generalizable.

D. A set of questions about linkages the program has with other key service components and about the context within which they operate. This is the same for all.
E. A set of "generic" questions for individuals who may be working closely with the HMD programs; i.e., police, housing, entitlement program staff.

Note that some modifications to these outlines and to individual questions will be needed in instances where the sequence or type of questions are not relevant to the particular program you deal with. The questions should also be modified in cases where the telephone interviews have already provided the information at the level of details desired.

The final product resulting from these site visits combined with the information obtained in telephone interviews and written documents collected will be used to address the following six key questions.
These questions also guided the development of the field instruments contained in Guidelines A through E.

**KEY CASE STUDIES QUESTIONS**

1. What are the goals (e.g., (a) treatment and (b) self-dependency) of the county's HMD programs as seen by CDMH officials, program directors and staffs? What do they see as the county's overall strategy to achieve these goals and how do they see their respective programs fit within it? Within the county mental health system?
   
   - Are the intent of the various providers consistent with each other?
   - Are the goals consistent with legislative intent? If no, why not.
   - Is actual service delivery consistent with the stated goals? If not, why not.

2. What segments of the homeless and mentally disabled population do the programs target and then actually serve?
   
   - How is the intended target population defined?
   - What types of clients are actually served?
   - What type of clients is program not able to serve and why?

3. What techniques are used to engage HMD individuals and with what success? What major problems have arisen in outreaching to the HMD and how have (or could) they be(en) overcome?

4. What techniques are used to assure continuity and coordination of care and with what success? What difficulties are being encountered in this respect and how are (or could) they be(en) overcome?

---

1We are specifically concerned with three dimensions of this concept: (1) the "comprehensiveness" of the needs assessment; (2) the "comprehensiveness" of the service plan and the ability to carry it out; and (3) the degree to which HMDs move over time toward self-dependency.
5. What proportion of HMDs are served and to what extent are their needs met?

- What procedures or policies are used to prioritize allocation of resources?

6. How successful has the County HMD program been in achieving the following outcomes and why:

- Enhancing HMDs functional skills
- Securing access to entitlements programs
- Securing participation of HMDs in "mental health" treatment programs
- Improving HMDs living conditions
- Making permanent residential placements
- What problems have arisen in seeking to do the above?

Finally, we should be able to say something about the extent to which the HMD programs are integrated within the overall county service delivery system and why and the extent of unmet needs.
SITE-VISITS--GUIDELINE A

PROGRAM PHYSICAL CHARACTERISTICS

1. County: Orange...1 Yolo...2 Alameda...3 LA Skid Row...4

2. Program Name: ____________________________________________

3. Number of sites: ___

4. Nearness to concentration of homeless (Describe):

5. Nearness to mental health clinic (Describe):

6. Location within building: Street level .....1
                             Other (specify) .....2

7. Appearance of program facility (Describe):

8. Cleanliness of facility (Describe):

9. Capacity (from fire code req.): ____________________________

10. Number of clients: _______
    At (hours): ___________ ___________ ___________

    # ___________________ ___________________
11. Density of Use:  
- Crowded and chaotic ...1  
- Crowded, but orderly...2  
- Medium ................3  
- Low ....................4  

12. Are there guidelines for clients' behavior and/or length of stay?  
Yes ( )  No ( )  (Get copy)

13. Are the various activities provided by the program physically separated and well marked?  
Yes ( )  No ( )

Comments: ____________________________________________
______________________________________________________

14. Other.

______________________________________________________
______________________________________________________
______________________________________________________

Filled out by (name): ______________________  Date: _______
SITE VISITS--GUIDELINE B

PROGRAM INTENT

Select one or more staff persons to answer this component prior to initiating your program observations. It should be the staff person(s) whose activities you will be observing. [If the person you already interviewed on the telephone is the one person available for this, skip those questions they already have responded to.]

Explain first the purpose of the study and of your visit. Put the person at ease and stress that it is not an evaluation of their performance.

Before we go to the field (or before we tour the facility), I would like to ask you a few general questions about the nature of your program. First, and based on your experience:

1. What are you seeking to achieve for the HMD clients in this program?

2. Which of the major program activities are designed to achieve these goals?

3. How do you define the HMD population?

- What types of HMD clients are you primarily attempting to serve in this program?
4. What services do they need most?

* Which of these are provided by your program?

5. What indicators of program success do you use?

6. In your view what is the County HMD program as a whole seeking to achieve for the HMDs?

7. How does your program contribute to meeting these overall objectives of the county HMD program?

8. How is your program linked into the overall County mental health service delivery system?

9. What are the major gaps in service in the County?

10. How can these gaps be filled?
11. I will now read you a number of possible service activities. For each activity, please tell me whether it is performed by your program; by someone else for your program; or is not performed.

<table>
<thead>
<tr>
<th>Activities</th>
<th>Performed by:</th>
<th>Not Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Someone Else for the Program</td>
<td>Which Program?</td>
</tr>
<tr>
<td>a. Outreach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Intake/screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Needs assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Service plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Case management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Follow-up/Monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Referrals to entitlement programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Referrals to mental health clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Referrals for permanent housing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Name and Title of Respondent:

13. Length of time with program: ________

Background:
Formal training (highest degree/major): ________
Experience: ( ) mostly social services
( ) mostly mental health
( ) other (including ex-homeless; specify)

14. Name of interviewer: ___________ Date: ___________
OUTREACH OBSERVATION SHEET

CONTEXT OF THE CONTACT
Date: _______ Time of Day: _______

Location: ____________________________
Frequency this location visited: _________

What prompted contact?
___ routine "on-street" visit
___ response to call (from whom: _________)
___ routine visit to another program
___ other (specify: ______________________)

OBSERVATIONS ABOUT THE CONTACT
Information About Individual
Contact Status
___ known to team; not yet engaged
___ new to team
___ previously served

Demographics
Age: _______
Race: _______
Sex: _______
Other: __________

Appearance:
___ Dirty or disheveled
___ Inappropriate dress for season
___ Inappropriate dress for sex
___ Body odor
___ Outlandish dress
___ Other (Describe: ______________________)
Was individual obviously high or intoxicated?
___ Yes  ___ No

Did individual's behavior seem unusual or bizarre?
___ No  ___ Yes -> Explain:_____________________

Response to Approach
___ Hostile
___ Nonreceptive, but not hostile
___ Frightened
___ Receptive
___ Other (Describe:_____________________

Observations About Outreach Worker

Method of Approach:
___ Actively approached individual
___ Individual approached worker
___ Other (Describe:_____________________

Length: ______

Content:

___ Conversation only/no services offered
___ Services offered/discussed

_____________________
_____________________
_____________________
_____________________

___ Services accepted

________________________
7. What special challenges are posed by the HMD who also have substance abuse problems? What can be done to serve this population?

8. I would like to get a general sense of the level of activity that occurs during a typical week.

[Indicate whether the figures apply to the respondent only or to the outreach program as a whole]

a. How many new contacts do you make each week? 

b. How many ongoing contacts do you have each week? 

c. What percent of those you seek to engage eventually accept referrals to social services? 

d. What percent of those you seek to engage eventually accept mental health services? 

e. What percent of those you have engaged were eventually placed in permanent housing arrangements? 

f. How often last month did you initiate a 5150?
   If none, do you ever? ___ Yes ___ No
   If yes, what is the process of initiating a 5150?
9. What percent of the County HMD population are you able to outreach to?

10. Name and title of respondent: ________________________________

Length of time with program: ________________________________

Formal training (highest degree/major): ________________________________

Experience: ( ) mostly social services
( ) mostly mental health
( ) other (including ex-homeless; specify)

11. Name of interviewer: ____________________________ Date: ______
SITE VISITS: GUIDELINE C.1
SERVICE ACTIVITIES OBSERVATION: OUTREACH

The purpose of this component is to document the engagement techniques used with the HMD and assess their relative effectiveness.

The questions below are intended to serve as a reminder of what you should cover during your observations and conversations with staff. It should be adjusted, as necessary, to the specific situation. Once your field observations are completed, you should review your observations with the outreach worker to obtain a sense of the extent to which the activities your observed are "typical" (e.g., how often do situations such as the ones you saw occur) and to follow up on any questions about the encounters.

OBSERVATION GUIDELINES

You should complete one of each of the attached forms for each individual outreach contact. You should not become involved in the encounter itself and should probably ask questions only after leaving an area.

POST-OBSERVATION QUESTIONS

1. Were the encounters I observed today "typical"? If yes, how often do you have encounters like these? If no, describe how these differed from what you usually do.

2. From your perspective, were the encounters I observed today:

   • __ About as successful as you usually experience
• More successful than usual
• Less successful than usual

What factors do you consider in judging "success"?

3. Do you change your approach and engagement techniques depending on whether the client is: (1) new to you; (2) an individual you have approached recently and repeatedly; (3) a "recycled" client? If so, describe some of the differences:

4. What are the major difficulties you experience in the course of conducting outreach activities? How do you overcome these problems?

5. What is the usual length of time you spend attempting to engage someone? When, if ever, do you give up?

6. What proportion of those you have approached cannot, or will not, be engaged? What are the characteristics of these clients? Can, or should, anything be done for them?
Other topics of conversation

Disposition

_____ Voucher for shelter

_____ Transportation to services

_____ Appt. for services

_____ Agreement to talk again

_____ Info list
SITE VISITS--GUIDELINE C.2

SERVICE ACTIVITIES OBSERVATIONS--ALL OTHERS

The primary purpose of this component of the case studies is to document how HMDs, once brought into the system, are kept connected with services (continuity of care) and to identify the difficulties and assess the effectiveness with which it is done.

The following are to guide your observations and discussion with program staff at shelters, drop-in/socialization centers, HMD and non-HMD mental health clinics. If a function is not done by the program, always inquire why not and whether this is done by another program they work with.

Once your field observations are completed, you should review your observations with one or more respondents to obtain a sense of the extent to which what was observed is typical and to pursue in further detail items you perceive are important.

As a result of the responses to Guideline B and from the telephone interviews, you will know before you begin which activities are not done within the program. You can skip the questions pertaining to these activities after having inquired about why they do not do it?

A. INTAKE/SCREENING/NEEDS ASSESSMENT

Purpose: Document extent and length of intake/Screening procedure. Get a sense of capacity to serve the various subgroups of HMDs.

1. Are there written procedures for screening/intake of new clients? (ask copy) (Ask only if not already known).

If there is no screening, ask why not?

What is the purpose of the screening?
2. What are the different types of clients served?

3. Are there types of HMDs the program is not able (or will not) serve? Describe and why not?

PROBE: About dual diagnosis

- Is anyone else serving them? Who?

4. If program has a waiting list (or has to turn HMD client away), how long is the waiting list (how many a week do they turn away)?

- What guidelines/priorities are used to decide who gets served?

5. At what point are service needs determined for a new client? (If written, ask for copy)

If not performed, why not?

What needs are included in the assessment (basic financial, subsistence, medical care, mental health care, vocational training, etc.)?

Who does it and how long does it take?
6. How do you make sure they get what they need?

B. CONTINUITY OF CARE

Purpose: Document methods for keeping HMDs connected with services

7. Describe the means by which clients are engaged?

LOOK FOR:
Use of uniform script or adjustment of approach to each client
Key things outreach worker try to communicate to individual
Ways to overcome client resistance/aggressiveness if any.
Services they offer first, second, etc.
Whether they offer mental health services at all, if no why not?
Do they screen/do a needs assessment/

8. What methods are used to encourage individuals to stay in treatment? How successful are you? For Whom? Do methods differ by type of HMDs?

9. How long is an individual allowed to stay in the program?

Do you make exceptions? For what reasons and for whom?

When individuals leave because they reached the time limit, where do they go?
10. Does every client in your program has a service plan?

If NO, Why not? Who does? Who prepares it? What is its content (get form)?

If YES, Who prepares it? What is its content (get form)? Which services are offered? Which are most often accepted?

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* How often is plan reviewed, updated, revised?

* How do you assure implementation of service plan? How successful are you?

11. Is every client in your program assigned a case manager?

If NO, Why not? Who is assigned one?

If YES, Who is the case manager? What are his/her functions?
12. If a client is referred to another program for service, do you follow-up with the client? With the other program staff?

If NO, why not?

If YES, have you encountered any difficulties in keeping track of HMD clients?

13. Overall, have you encountered difficulties in serving HMDs? How have you surmounted them?

* Are they more (or less) difficult to serve than your usual clients? Why?
C. PROGRAM ACTIVITIES

[See socialization/shelter observation sheets]

At the end of your observations and conversations with staff, you should go back over the above with the main respondent to determine whether what you have observed is typical. You should also cover the following additional questions:

14. On the average, what combination of services do HMD clients receive while they are in your program?

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15. From your point of view, how typical were the activities of this morning (afternoon, evening)? If NO, describe how these differ?

17. On average, how long does an individual stay in your program?

18. What do you consider a successful outcome from your program? How successful are you?
19. What do you do if someone you thought had successfully completed your program comes back? How frequently does this happen? Who is most prone to this happening?

20. Please can you tell me:

[Indicate whether the figures given refer to the respondent only or to the program as a whole. Seek to get the latter]

How many new HMD clients are accepted a day? ______
How many continuing HMD clients are currently being served? ______
What percent of those you serve accept referrals to (other) social services? ______
What percent of those served accept referrals to entitlement programs? ______
What percent of those served accept referrals to mental health services? ______
What percent of those you have served eventually were placed in permanent housing arrangements? ______
Last month, how many 5150s did you initiate? If none, have you ever? ______

(Ask for any report on program activities, client characteristics and/or outcomes)

21. Name and Title of main respondent _________________________
Length of time with program _____________________________
Formal training (highest degree/major): ___________________
Experience: ( ) social services
( ) mental health
( ) Other (specify)

22. Name of Interviewer _______________ Date __________
SHELTER OBSERVATION SHEET

DESCRIPTION OF SHELTER

Name: ______________  Opens at: ____________
Address: ______________  Closes at: ____________
Date: ______________  Days of operation: M T W TH F S S
Time of day: ____________  Limits on stay: ____________
Enforced? ____________

CLIENT POPULATION AND ACTIVITIES

___ Single Males  ___ HMD Only
___ Families  ___ HMD and other homeless
___ Single Women

# Beds: _____  # reserved for HMD: _____

# Clients today: ____________

Compared to average this was:
___ more than usual
___ fewer than usual
___ about the average

Meals served: _____ dinner  --> only for residents? _____
              _____ breakfast  --> only for residents? _____

Activities:

_____ Outreach workers
_____ Eligibility for entitlement
_____ Counseling: group
_____ Counseling: individual
Referrals

Staffing:

___ number of total staff
___ average staff/client ratio

Requirements for residents:

___ Must arrive by certain time (Specify:__________)
___ Appearance
___ No alcohol, other substances
___ Must take medication
___ Participation in upkeep of shelter
___ Must work
___ Other (Specify:__________________________ )
SOCIALIZATION CENTER OBSERVATION GUIDELINES

CONTEXT OF THE VISIT

Name of Center: ________________________________
Address: ______________________________________

How long in this location? ______

Days Open: Monday Tuesday Wednesday Thursday Friday
Saturday Sunday

Hours Open: 8-5 evenings 24 hours Other: ______

Date of visit: ________________
Time of day: ________________

ACTIVITY OBSERVATION

# of clients: __________

___% new
___% regular

___% HND
___% MD

___% Other (Specify: ________)

Activities Clients Currently Engaged In:

#Clients Activity

______ Formal class (Content: ________________________)
______ Watching TV
______ Hanging out
______ Intake
______ Field trip (will have to ask about this)
______ Other (Specify: ________________________)

Facilities:

______ Mail boxes  ____ Typewriter (for client use)
______ Storage  ____ Phones (for client use)
______ Kitchen  ____ Showers
Bathrooms
Laundry

Other (Specify: __________)

STAFFING PATTERN

# of staff: ___

Activities engaged in:

Teaching class
Conducting intake
Talking with clients
Paperwork
Other (Specify: __________)

Showing us around
Making phone calls
for referrals
Formal counseling

QUESTIONS ABOUT CENTER OPERATIONS

# hours during which formal, scheduled activities take place

(IF there is a schedule, obtain a copy.)

How long do clients stay each day on average? ______

Over what period of time do people come here regularly? ______

What is the usual staff/client ratio? ______

How many different individuals are on staff? ______

Are the number of clients here today:

More than usual
About average
Fewer than usual
SITE VISITS--GUIDELINE D

The purpose of this component is to obtain a systematic qualitative assessment of the linkages the program has with key other service components and of the context within which they operate. One or more program staff can be approached to respond to this questionnaire. Ideally, at least one of the respondents will be the person whose activities you have spent the most time observing.

1. In serving your clients, do you have any special arrangements (e.g., outstationed worker, training) with public agencies providing entitlements (i.e., GR, AFDC, SSI, Medicaid, Medicare)?

   If NO,
   a. Why not?
   b. Would it be useful if you did?

   If YES,
   a. Which ones (list):

   b. Describe ties? Are they informal or formal (ask for copies of MOU)?

   c. In the last month, how many HMD clients for which you have
      1) started in the process: #
      2) obtained entitlements: New: #
                                Reinstatements: #

1.1 On the average, what is the length of time between application and a decision?

   GR
   AFDC
   SSI
   Medi-Cal
   Medicare

2. Are you able to make direct referrals for mental health services?
If NO,
a. Why not?

b. Would it be useful if you were able to?

If YES,
a. Which providers? (list)

b. Describe ties? Are they informal or formal (ask for copy of MOU)?

c. In the last month, how many HMD clients have you

1) started in the process: #
2) placed in mental health programs #

2.1 On average, what is the length of time between referred and beginning of mental services? To what do you attribute the delay, if any?

for assessment?
for outpatient services?
for drug evaluation?
for those in an acute episode?
for those who have been stabilized?
for treatment in residential facilities?

3. Do you have any ties with the police?

If NO,
a. Why not?

b. Would it be useful if you did?

If YES,
a. Describe ties? Are they informal or formal (ask for copy of MOU)?

b. In the last month, for how many HMD clients have you:

1) sought police assistance #
2) provided assistance #

4. Does your program make direct placements in:
A. Mental health residential treatment facilities
B. Shelters
C. SROs
D. Semi-supervised living (boarding houses)
E. Families

F. Other independent living (specify) ________

If NO,

a. Why not?

b. Would it be useful if you did?

If YES,

a. Where?

b. Describe how?

c. In the last month, how many

a) placements did you seek to make? Where?

b) actual placements did you make? Where?

4.1 On the average, what is the length of time between your request and the actual placement?

A. Mental health residential treatment facilities ________

B. other permanent housing ________

What factors affect time required to place someone in LT Housing?

5. Overall, is your program contributing towards moving the HMD into a permanent (supported or not) residential situation? What is this contribution? What major difficulties or gaps in service delivery do you see making achievement of this goal difficult?
SITE VISITS--GUIDELINE E

INTERVIEWS WITH SELECTED NON-HMD SERVICE PROVIDERS

Use the following questions as guidelines for your interviews with social services, entitlement programs, housing, and police representatives as needed. These questions are generic and may need to be adjusted to the respective county and programmatic circumstances.

The purpose here is to get a measure of their ties with the HMD programs, of their ability to serve the HMD population, and of their views regarding the effects of HMD on their activities.

Before you begin with the questions, you should tell them what you are doing and why you are talking to them. Presumably, you have identified them either as having close ties with HMD programs, or as being major barriers in the HMD programs' ability to serve the HMDs.

1. Were you serving HMDs before HMD?

2. How are you serving them now?

- What arrangements/ties do you have with the following HMD programs?

PROBES: Formal/informal arrangements (get copy)
They refer to us
We refer to them
They/we provide training
3. Do you refer HMDs to HMD or mental health programs?
   If YES,
   How do you identify those you refer?
   How many a week do you refer?
   How do you know whether your referral was accepted for service?
   What positive effects have there been on your operations?
   What negative, if any?

4. Do any of the following programs HMD (list) refer HMDs to you for services or help?
   If YES,
   How many a week are referred to you?
   For what reason?
   Do you give them special treatment?
   In what ways?

5. Have you made any changes in your program operations, services, and/or policies to enhance access for the HMDs?
6. Have you encountered difficulties in serving the HMDs?

What actions have you taken to surmount these difficulties?

What percent of your applicants/caseload are HMDs?
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<tr>
<td>Other</td>
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Name of Program: ____________________________

Date of Survey: ____________________________
Appendix D

INTERVIEW INSTRUMENTS FOR TELEPHONE SURVEY
COUNTY DIRECTOR OF MENTAL HEALTH INTERVIEW PROTOCOL
HMD PROGRAM REVIEW

IDENTIFYING INFORMATION

- COUNTY: ___________________
- NAME OF INTERVIEWEE: ___________________
- DATE OF INTERVIEW: ___________________
- NAME OF INTERVIEWER: ___________________

INTRODUCTION

Hello, my name is _____ and I am calling from The RAND Corporation in Santa Monica. RAND is a private, nonprofit corporation established to conduct research about significant issues in public policy. We are conducting a review of the program for the homeless mentally disabled for the state. I hope that Tom Rietz from the State Department of Mental Health has let you know that we would be calling.

We are conducting telephone interviews with a variety of individuals involved with the Bronzan program in your county and 16 other counties. The purpose of the telephone interviews is to obtain more detailed information about your experience with program implementation, how those programs fit with the overall county mental health program strategy, and what the effect of those programs has been to date. Some of the questions I will be asking you involve factual information while others ask for your opinions based on your own experience. Do you have any questions before we begin?

I wonder if you would send me a copy of your county's Short-Doyle plan for FY 86/87. I am primarily interested in Part B, but would like both parts if that is possible.

We would also like to interview at least one member of the Board of Supervisors in your county regarding the Bronzan program. Could you suggest someone on the Board who might be appropriate?
1. BACKGROUND: MENTAL HEALTH DIRECTOR

I would like to begin by asking a few questions about your own background.

1. How long have you been the Director of Mental Health for ______ county? __________

2. What were you doing before you became the Director of Mental Health?

3. What is your educational background?

II. PRE-BRONZAN ACTIVITIES

Now I would like to ask you some questions about what was being done in ______ county prior to enactment of the Bronzan legislation to serve the homeless mentally disabled.

4. Prior to implementation of the Bronzan program in your county, what were the most critical areas of underservice for the HMID population?

   o No real underservice
   o Shelter
   o Food, clothing, other basic needs
   o Crisis residential facilities
   o Transitional residential facilities
   o Long term residential facilities
   o Low cost housing
   o Outreach services
   o Medical treatment
5. What, if anything, was being done by the private and/or public sectors to serve the HMD population prior to the Bronzan program?

Nothing was being done

Approximately how much was being spent on these programs?
PUBLIC: $______ PRIVATE: $______

III. BRONZAN PROGRAM

Now I would like to ask you some questions about the Bronzan program in your county.

6. Where is the homeless coordinator located in the administrative structure of your county department of mental health?

7. To whom does the coordinator report?
8A. What are you trying to accomplish with the Bronzan program in your county?
   o Establish ongoing contact with the HMD
   o Provide basic subsistence services to the HMD
   o Provide mental health services to HMD not previously served
   o Place and maintain HMD in long term housing arrangements
   o Get HMD off the street
   o Other (Specify: _____________________________)

8B. How are you seeking to achieve this/these goal(s)?


PROBE IF NEEDED:
   o Who are they trying to serve?
     -- severely mentally ill (define)?
     -- long term homeless
     -- recently homeless
     -- at risk group
     -- special population groups
   o What services are they trying to provide?
     -- outreach
     -- basic subsistence (shelter, food, clothing)
     -- mental health services
     -- residential services (crisis and transitional)
     -- long term housing options
     -- other

9. Excluding the Bronzan funded programs, are there other programs serving the homeless in your county?
   NO   YES---specify (if too many, ask for a list to be sent)
Do any of these programs specifically serve the HMD?

NO  YES---specify

Do you know the approximate amount of money that is spent on the programs for the homeless? $_______

(NOTE: Units of service as an alternate).

10. Does the county have an adequate mix of beds to serve the HMD?

YES  NO

If NO, what do you estimate are your needs in each category?

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ADEQUATE?</th>
<th># BEDS/UNITS NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>Shelter</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>Crisis residential</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>Transitional housing</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>Long term residential</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>Independent living</td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>Low cost housing</td>
<td>YES NO</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: IF DIRECTOR CANNOT GIVE ESTIMATES, ASK IF THERE IS SOMEONE WHO CAN -- NAME: __________ PHONE: __________
11. Do you keep statistics on the number of HMD placed in permanent housing?
   NO  YES----> Please send a copy of any reports.

   Last year, approximately how many placements were made into permanent housing (including residential treatment)?

   ______ placements
   ______ don't know, but _______ at _________ knows.
   (telephone #)

   Is this level of placements meeting your expectations?

   ______ YES
   ______ NO, lower than I expected
   ______ NO, higher than I expected

   Why?

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

   In the future, do you expect the county will be able to increase the number of permanent placements?

   YES  NO

   Why?

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

12. Would you say that coordination in serving the homeless is greater now than it was two years ago?
YES   NO

If YES, explain what coordination activities are taking place.

________________________________________________________________________

________________________________________________________________________

13. In your opinion, has the Bronzan program in your county had any significant effect on:

A. Community awareness of the difference between the general homeless population and the homeless mentally disabled  YES  NO

________________________________________________________________________

________________________________________________________________________

B. the provision of services by private mental health service providers  YES  NO

________________________________________________________________________

________________________________________________________________________

C. the approach to treating the HMD by county mental health providers  YES  NO

________________________________________________________________________

________________________________________________________________________

D. the provision of services by social service agencies  YES  NO

________________________________________________________________________

________________________________________________________________________
E. the attitudes and support by the Board of Supervisors


F. The police interaction with the HMD


14. In your opinion, is your Bronzan program able to:

A. Engage and treat the most severely mentally disabled homeless? YES NO


B. Serve the HMD who also have drug and alcohol abuse problems (dual diagnosed)? YES NO


C. Maintain HMD clients in the system on a long term basis? YES NO


15. Overall, do you think the Bronzan program is an effective response to the problems of the HMD?
16. Are there any changes you would like to see made to the Bronzan program?


17. If your Bronzan allocation was increased by 30 percent, how would you spend the additional funds?


CLOSING

Thank you for your time in answering these questions. We appreciate the cooperation we have received. I would like to give you this opportunity to add any thoughts or comments you might have about the HMD program that may not have been covered in this interview.


When we have completed writing up the interviews in your county we will be sending you a copy for review. This will give you an opportunity to alert us to any factual errors or serious oversights. Thank you once again for the time you have taken today.
IDENTIFYING INFORMATION

- COUNTY: __________________________
- NAME OF INTERVIEWEE: __________________________
- NAME OF PROGRAM: __________________________
- DATE OF INTERVIEW: __________________________
- NAME OF INTERVIEWER: __________________________

INTRODUCTION

Hello, my name is ______ and I am calling from The RAND Corporation in Santa Monica. RAND is a private, nonprofit corporation established to conduct research about significant issues in public policy. We are conducting a study of the Bronzan program for the homeless mentally disabled at the request of the state Department of Mental Health. ______ should have indicated that I would be contacting you.

As part of this study, we are conducting telephone interviews with a variety of individuals involved with the Bronzan program in your county. We are also talking to individuals in 14 other counties. We are particularly interested in learning about the implementation of the Bronzan program in this county from your perspective as a program director. Some of the questions I will be asking you involve factual information while others ask for your opinions based on your own experience. Do you have any questions before we begin?

INFORMATION ON PROGRAM DIRECTOR

I would like to begin by asking you a few questions about yourself:

1. How long have you been in your current position? ______

2. What education and/or training do you have?
o Social service discipline
o Mental health discipline
o Other (SPECIFY: ____________________________)

BACKGROUND INFORMATION ON PROGRAM

Now, I would like to ask you a few general questions about your agency (program).

3. When did this agency begin operating?

Month: _____ Year: _____

4. What services does your agency/program provide directly? Here I am interested in all services provided, not just those funded by the Bronzan program.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

5. What is the total agency budget? $_______

What proportion of your budget is funded through the Bronzan program? ____% (or FTEs ______)

What proportion of the agency budget comes from private sources? ____% (or FTEs ______)

6. Did the Bronzan funds represent a net addition to the annual operating budget of your agency?
YES       NO

If no, why not?

---------------------------------------------

7. To which service(s) do you allocate the largest share of your funds?

---------------------------------------------

BRONZAN FUNDED ACTIVITIES

Now, I would like to ask you about the services you provide using Bronzan funds.

8. What new services have the Bronzan funds allowed you to provide?

___ NO NEW SERVICES BEING PROVIDED

___ YES, specify:

---------------------------------------------

9. Have the Bronzan funds allowed you to expand services you were already providing?

NO, ONLY PROVIDING NEW SERVICES ___

YES, specified below:
10. Do you operate the activities supported by Bronzan funds separately from your other activities?

   YES    NO
If yes, in what way are the activities separate?

11. How long did it take to make your Bronzan funded programs fully operational?

   ___ days
   ___ not yet fully operational

12. In fiscal year 86/87, what proportion of your Bronzan allocation was spent?
   o None
   o Less than 50%
   o 50-75%
   o More than 75%
   o All

13. What are the primary reasons you have not spent your full allocation?
   (Mark all that apply.)

   o Delays in signing the contract
   o Difficulties in hiring staff
   o Space was not immediately available
• Community opposition
• Problems obtaining necessary facility license
• Delays in construction/rehab of facility
• Difficult negotiations with other agencies
• Had to change our original plans
• Other

For any marked, please explain the nature of the problem:

______________________________________________________________
______________________________________________________________

14. What measures, if any, have you taken to resolve these difficulties?

______________________________________________________________
______________________________________________________________

BRONZAN PROGRAMMATIC ACTIVITIES

Next, I would like to ask you about specific components of your
Bronzan program activities and the characteristics of the population you
serve.

A. Population Characteristics
15. What is the demographic profile of the population you serve?

• Demographics
  • Age: __________
  • Race: __________
  • Sex: __________
  • Other: __________

16. What proportion of the population you serve is currently homeless
as compared to at risk of homelessness? __________% homeless
17. What proportion of the population you serve is mentally disabled? ___%

Of the mentally disabled you serve, what proportion are severely mentally ill? ___%

How do you define severely mentally ill? ____________________________________________

Of the mentally disabled you serve, what proportion have dual mental health/substance abuse diagnoses? ___%

18. Do you serve any special population groups? ____________________________________________

B. Training
19. Does the county provide any training for HMD program directors and staff?

YES  NO

If yes, what kind of training is offered?

- About mental illness
- About medication side effects
- Techniques for interviewing the mentally disabled
- Techniques for engaging the mentally disabled
- Reporting procedures for the MIS
- Treatment and handling of individuals with dual diagnosis
- Other (SPECIFY: ____________________________________________)

Do you believe there is a need for (additional) training?
YES       NO

If yes, what type of training is needed?

________________________________________

________________________________________
C. Intake/Eligibility Determination

1. What are the basic activities performed at the time a client first enters your program (exclude outreach)?

   No intake activities

   - Screen for homelessness
   - Screen for "at risk of homelessness"
   - Screen for mental illness
     --> Do you determine severity of illness? YES NO
     --> Do you make a DSM-III diagnosis? YES NO
   - Screen for drug or alcohol abuse
   - Make other eligibility determinations for your program
   - Determine eligibility for entitlements (e.g., SSI, Medi-Cal, VA)
   - Determine eligibility for other services (e.g., voc rehab)
   - Other (Specify: ____________________________)

2. Do you have a written screening protocol? NO YES---> Ask for copy.

3. Do you ever turn away anyone for service?

   Yes ______ No ______

   If YES, how many do you turn away on an average day ______

   What are the main reasons? (PROBE if necessary.)

   - Do not provide services person is looking for
   - Substance abuse is primary problem
   - Operating at capacity
   - Person does not meet eligibility criteria
     --> Which ones? ____________________________
   - Other (specify: ________________________)

4. Who does the initial screening for mental illness?
- No one, program does not do this
- Case managers
- Diagnostic specialist
- Outreach team
- Intake supervisor
- Social worker
- Psychologist
- Psychiatrist
- Another agency under contract with us
  Name of agency: _______________________
- Other (specify: _______________________

5. Do the individuals conducting screening receive any special training about the HMD population?
- NO  YES--> What kind? ________________________________
D. Outreach

1. Does your program have an outreach component?

   YES _____  NO _____

   If YES, where are outreach activities conducted?

   o In the streets, parks, etc.     YES     NO
   o At jails, police stations       YES     NO
   o At shelters                     YES     NO
   o Soup kitchens                   YES     NO
   o At bus stations                 YES     NO
   o At SSI offices                  YES     NO
   o At General Relief offices       YES     NO
   o VA Administrative offices       YES     NO
   o Hospital emergency rooms        YES     NO
   o At other programs serving the homeless  YES     NO
   o Other (Specify:_________________)

   What proportion of outreach occurs "on the street" as compared to
   in offices or other program providers? _____ of _____ on the street

2. I would like to ask some questions about the size and scope of
   your outreach efforts.

   a. How many staff do this? ______ FTE
      What are their qualifications?

      o Paraprofessional
      o Mental health professional (Specify:__________)
      o Social worker
      o Other professional (Specify:__________)
      o Formerly homeless individual
      o Other (Specify:__________)
b. How many days a week? 1 2 3 4 5 6 7

c. During which hours of the day or night?
   _____ 9-5
   _____ 24 hours
   _____ Other (Specify: ____________)

d. Do you open charts on these individuals or keep track of contacts in any other way?


3. Describe what the outreach team does in a typical contact.


What actual services (food, transportation, shelter) are offered on the street?


What is the next step once a client has been engaged?
(NOTE: If necessary, probe whether client is referred and transported to a central location or whether he/she is referred to programs providing the services the client needs/wants.)

4. How many contacts do you make in an average day/week/month? ____

What proportion of those are with new persons? ____

5. What proportion of those you contact refuse services, even after numerous attempts? ____

6. What factors contribute to refusal of services?

PROBE: o Does it depend on the population targeted?
    -- severity of mental illness
    -- length of homelessness
    -- prior experience with the mental health system
    o Does it depend on characteristics of outreach workers?
    o Does it depend on services offered?

7. Can and/or should anything be done for those who refuse services?

PROBE: Would greater involuntary authority be useful?

8. On average, how long does it take before an HMD person is willing to accept services?

| CONTACTS | TIME PERIOD |
A. Basic services
B. Mental health services

Is there a point at which you stop trying to engage an individual?
NO YES --> When?

9. What factors seem to be associated with acceptance of services?


10. What services are most often accepted?


E. Case Management

1. Does your program/agency provide case management services?
   __ YES, directly
   __ YES, under contract to someone else
   __ NO

2. What are the objectives or goals of your case management services?

3. What does your case management activity include:
   o Crisis intervention only
   o Follow up services (e.g., medications)
   o Regular client need assessments
   o Preparation of written service plans
   o Securing and maintaining entitlements
   o Referrals to housing
   o Advocacy
   o Transportation
   o Support services
   o Mental health services
   o Regular case review
   o Other (Specify: ____________________________)

4. Who do your case managers receive referrals from?

   PERCENT
   o Client self-referral
   o Outreach workers
   o Police
   o Jail authorities
5. Do your case managers schedule regular appointments with clients?
   YES ---> How often?____
   NO ---> What determines when a client is seen?

6. How many staff provide case management services? ___ FTE

7. What are their qualifications?
   o Paraprofessional
   o Mental health professional (specify:___________)
   o Social worker
   o Other professional (specify:___________)
   o Other (specify:___________)

8. What is a typical case load? _______

9. How often, on average, do case workers see clients face-to-face? 
   __________________________

10. How long are cases kept open on average? _____________

11. What are the main referrals made by case managers?
    HOW MANY? (Week/Month)
    o No referrals made
    o Mental health services _______
12. Relative to the population traditionally seen in the county mental health system, how well are you able to maintain continuity of care for the HMD?

- About the same as the traditional population
- Better than the traditional population
- Not as well as the traditional population
- Other: ____________________________

13. Do you develop a written service plan for every client?  YES  NO

a. If NO, what proportion do not receive one ______

b. If YES, who is responsible for service plan preparation?

- Diagnostic specialist
- Social worker
- Case manager
- Intake worker or supervisor
- Psychiatrist
- Psychologist
- Other agency

c. If YES, what factors enter in the decision to prepare one?
14. To what extent have you been successful in developing service plans for the HMD?
   ○ Developed for most of them
   ○ Developed for about half
   ○ Rarely developed
   ○ Never developed
   ○ Other (specify: ____________________)

15. Do you try to involve family or friends in the development of service plans for the HMD?  YES  NO

   If yes, how successful have you been in engaging family members or friends in the development of service plans?
   ○ Most of the time
   ○ About half of the time
   ○ Rarely
   ○ Never

14. What proportion of the HMD drop out of services before completing their service plan? _____% 

   What are the main reasons for termination of services?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
F. Mental Health Services

1. Do you provide short term/crisis residential services?

   YES  NO---> Do you have a place to refer clients for these services?  NO  YES---> Formal agreement?
   |  NO  YES

   If yes or referral capability,

   Do you have both 1-14 and 15-30 day stay facilities?  YES  NO

2. What proportion of your clients are referred from each of the following sources?

   | PERCENT
   | o Self
   | o Outreach workers
   | o Police
   | o Jail authorities
   | o Dept. of social services
   | o Hospitals
   | o Other agencies, specify

3. What is your bed capacity?

   _____ beds (1-14 day)  _____ beds (15-30 day)

4. What is the average length of stay?

   _____ days (1-14 day)  _____ days (15-30 day)

5. What proportion of clients are referred to each of the following at the termination of their stay?

   | PERCENT
   | o Transitional housing
   | o Board and care
6. What factors affect your ability to make placements?
   - Obtaining SSI eligibility
   - Client cooperation
   - Client history (Specify: ________________________)
   - Facility availability
   - Other (Specify: ________________________)

7. Do you do any follow-up on clients once they have been placed?
   NO  YES--->

8. Do you provide transitional residential services?

   YES  NO--->
   | NO--->
   | clients for these services? NO YES--->
   | agreement?
   | NO  YES

   If yes or referral,
   What kind of facility? ________________________

9. What proportion of your clients are referred from each of the following sources?

   PERCENT
   - Self
   - Outreach workers
   - Police
   - Jail authorities
   - Dept. of social services
   - Hospitals
10. What is your capacity? ___ beds

11. What is the average length of stay? ___ days

12. What proportion of clients are referred to each of the following at the termination of their stay?

- Board and care
- Independent living
- Back to street
- To relative
- Other
- Don't know

**PERCENT**

13. What factors affect your ability to make placements?

- Obtaining SSI eligibility
- Client cooperation
- Client history (Specify:____________________)
- Facility availability
- Other (Specify:____________________)

14. Do you do any follow-up on clients once they have been placed?
   
   **NO**  **YES—>** What proportion remain in placement? ___%
G. Drop-In/Socialization Centers

1. Do you have a drop-in/socialization center program?
   NO  YES

2. Do you allow for anonymity of those using the center?
   NO  YES

3. Is there some type of formal "gatekeeper" who determines entry to the center?
   NO  YES

4. Is the center located in a "storefront" setting or is it inside a building/otherwise off the street?
   ___storefront  ___off street

5. Do you open charts on clients?
   NO  YES-->At what point?

6. How many clients do you have on an average day/week/month?
   ____

7. What proportion of clients return consistently? ____%

8. What proportion of clients are effectively referred to other services? ____%

   How long does such referral take?

9. Do you provide actual services at the center?
   NO  YES-->Which ones?
   o Food
   o Clothing
   o Showers
   o Bathrooms
   o Referrals (to where?______________)  
   o On-site mental health worker
- Vocational/rehabilitation services
- Mail box
- Other (Specify:______________________ )
H. Generic Section: For Programs Not Covered Above

1. Please describe your program.


2. Who refers clients to this program?

PERCENT

- Client self-referral
- Outreach workers
- Police
- Jail authorities
- County mental health
- Dept. of social services
- Hospitals
- Other agencies, specify


3. How many clients do you see in an average day/week/month? 


4. Do you open charts or keep other records on clients?

NO   YES---> At what point? 


5. Who are you targeting services on?


6. Where are clients referred to?
7. What indicators of program success do you use?

________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

8. What proportion of clients drop out of your program prematurely?

_____ percent

IMPACT OF THE BRONZAN PROGRAM

Finally, let me ask you about the effects the Bronzan program has had on your agency and the clients it serves.

1. In your opinion, has the Bronzan program in your county had any significant effect on:

   A. Community awareness of the difference between the general homeless population and the homeless mentally disabled

       YES  NO
B. the provision of services by private mental health service providers

YES NO

C. the approach to treating the HMD by county mental health providers

YES NO

D. the provision of services by social service agencies

YES NO

E. the attitudes and support by the Board of Supervisors

YES NO

F. The police interaction with the HMD

YES NO

2. In your opinion, is your Bronzan program able to:

A. Engage and treat the most severely
mentally disabled homeless? YES NO

B. Serve the HMD who also have drug and alcohol abuse problems (dual diagnosed)? YES NO

C. Maintain HMD clients in the system on a long term basis? YES NO

3. Overall do you think the Bronzan program is an effective response to the problems of the HMD?

4. Has the Bronzan program improved the coordination of services for the HMD in your county? NO YES---> How?

5. Are there any changes you would like to see made to the Bronzan program?
5. If your funding was increased by 50 percent, how would you use the money?

OTHER COMMENTS

Thank you for your time in answering these questions. We appreciate the cooperation we have received. I would like to give you this opportunity to add any thoughts or comments you might have about the HMD program that may not have been covered in this interview.
IDENTIFYING INFORMATION

- COUNTY: ______________________
- NAME OF INTERVIEWEE: ________________
- DATE OF INTERVIEW: ________________
- NAME OF INTERVIEWER: ________________

INTRODUCTION

Hello, my name is _____ and I am calling from The RAND Corporation in Santa Monica. RAND is a private, nonprofit corporation established to conduct research about significant issues in public policy. We are conducting a review of the program for the homeless mentally disabled for the state. _____ should have indicated that I would be contacting you.

We are conducting telephone interviews with a variety of individuals involved with the Bronzan program in your county and 14 other counties. The purpose of the telephone interviews is to obtain more detailed information about your experience with program implementation, how those programs fit with the overall county mental health program strategy, and what the effect of those programs has been to date. Some of the questions I will be asking you involve factual information while others ask for your opinions based on your own experience. Do you have any questions before we begin?

INFORMATION ABOUT COORDINATOR

To begin with, I would like to ask a few questions about you and your job.

1. How long have you been the homeless coordinator for _______ county?
   _____ (If less than 12 months, was anyone in the job previously?)
2. What was your previous job?

3. What is your training/background?

4. What are your major responsibilities as homeless coordinator?

5. How many employees do you have reporting directly to you?

____ employees

PRE-BRONZAN ACTIVITY

Now I would like to ask you some questions about what was being done in ______ county prior to enactment of the Bronzan legislation to serve the homeless mentally disabled.

6. Prior to implementation of the Bronzan program in your county, what were the major areas of underservice for the HMD population?

- No real underservice
- Shelter
- Food, clothing, other basic needs
- Crisis residential facilities
- Transitional residential facilities
- Long term residential facilities
o Low cost housing
o Outreach services
o Medical treatment
o Acute inpatient mental health services
o Outpatient mental health services
o Socialization services
o Vocational and prevocational services
o Advocacy
o Other (SPECIFY: ____________________________)

7. What, if anything, was being done by the private and/or public sectors to serve the HMD population prior to the Bronzan program?

    --- Nothing was being done

7. What, if anything, was being done by the private and/or public sectors to serve the HMD population prior to the Bronzan program?

8. When your county first applied for Bronzan funding, it estimated that approximately __________ HMD persons were living in the county. Is this estimate still accurate or have you revised it?

    --- still accurate     --- has been revised

   If revised, what was the basis for the revision:

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
8A. When your county first applied for Bronzan funding it gave no estimate of the number of HMD living in the county. Do you now have such an estimate?

YES      NO

If yes, what is the estimate?

How was the estimate derived?

BRONZAN ACTIVITIES

Now I would like to ask you about the implementation of programs in response to the availability of money through the Bronzan program.

9. What are you trying to accomplish with the Bronzan program in your county?

- Establish ongoing contact with the HMD
- Provide basic subsistence services to the HMD
- Provide mental health services to HMD not previously served
- Place and maintain HMD in long term housing arrangements
- Get HMD off the street
- Other (Specify: ____________________________)

How are you seeking to achieve this/these goal(s)?

______________________________

______________________________

______________________________

______________________________
PROBE IF NEEDED:

- Who are they trying to serve?
  - severely mentally ill (define)?
  - long term homeless
  - recently homeless
  - at risk group
  - special population groups

- What services are they trying to provide?
  - outreach
  - basic subsistence (shelter, food, clothing)
  - mental health services
  - residential services (crisis and transitional)
  - long term housing options
  - other

10. Have there been any major changes in your program for the homeless mentally disabled since your proposal was submitted in FY 1985/86?

   _NO_   _YES_ (please specify below)

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

11. Excluding the Bronzan funded programs, are there other programs serving the homeless in your county?

   _NO_    _YES---specify (if too many, ask for a list to be sent)
Do any of these programs specifically serve the HMD?

NO  YES—->specify

Do you know the approximate amount of money that is spent on the programs for the homeless?

PUBLIC: $_____  PRIVATE: $_____  
(NOTE: Units of service as an alternate).

12. Do you have a list of all providers in the county currently providing services to the homeless and/or the homeless mentally disabled?

YES  NO

If YES, would you please send me a copy of the providers?

If NO, do you have a list of the Bronzan funded programs?

YES  NO

If YES, please send that list.
If NO, could you put a list together to send?

13. Do any of these programs focus services on special populations?

YES  NO
If yes, which populations?

- Children
- Young adults
- Elderly
- Single women
- Single men
- Families with children
- Minorities
- Refugees
- Other (specify: ________________________)

Do you have any jail diversion programs?

NO

YES----> How much is spent on it? $_______

14. Overall, how many Bronzan funded contractors do you have? ______

15. How were those contractors selected?

  sole source ---> On what basis? ______________________

  competitive ---> How many responded? ______________________

16. How did you decide when to provide services directly through the
    county versus contracting out for services?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

17. Does the county have an adequate mix of beds to serve the HMD?

  YES    NO
If NO, what do you estimate are your needs in each category?

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ADEQUATE</th>
<th># BEDS/UNITS NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care</td>
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<td>NO</td>
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<tr>
<td>Shelter</td>
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<td>NO</td>
</tr>
<tr>
<td>Crisis residential</td>
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<tr>
<td>Transitional housing</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Long term residential</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Independent living</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Low cost housing</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

NOTE: IF COORDINATOR CANNOT GIVE ESTIMATES, ASK IF THERE IS SOMEONE WHO CAN -- NAME: __________ PHONE: __________

18. We will be trying to interview the directors of up to five programs in your county. We are particularly interested in any programs you consider to be particularly innovative or successful and in outreach and case management programs. Could you give me the names and phone numbers for up to five program directors?

NAME: ______________________
PHONE: ______________________
PROGRAM TYPE: ______________________

NAME: ______________________
PHONE: ______________________
PROGRAM TYPE: ______________________

NAME: ______________________
PHONE: ______________________
PROGRAM TYPE: ______________________

NAME: ______________________
PHONE: ______________________
PROGRAM TYPE: ______________________
NAME: __________________________
PHONE: __________________________
PROGRAM TYPE: __________________

NAME: __________________________
PHONE: __________________________
PROGRAM TYPE: __________________

Would you prefer to contact these people before we call them, or may we call them directly?

____ Coordinator will call  ____ RAND contact direct

We may need to contact other programs in addition to these you have named. If so, we will call back to let you know.

We will also be interviewing a number of other individuals in your county. I wonder if you could give me the names and telephone numbers of appropriate individuals in each of the following categories:

DEPARTMENT OF SOCIAL SERVICES
NAME: __________________________
PHONE: __________________________

CITY POLICE, SHERIFF, OR DISTRICT ATTORNEY
NAME: __________________________
PHONE: __________________________

ADVOCATE FOR THE HOMELESS
NAME: __________________________
PHONE: __________________________

DIRECTOR OF JAIL DIVERSION PROGRAM (if any)
19. In the first year of funding (FY 85/86), what proportion of the Bronzan allocation were you able to spend?

- None
- Less than 50 percent
- 50-75 percent
- More than 75 percent
- All

20. In the most recent fiscal year (86/87), approximately what proportion of the allocation, including rollover funds, did you spend?

- None
- Less than 50 percent
- 50-75 percent
- More than 75 percent
- All

21. If you have not fully spent your FY 86/87 allocation, what are the major reasons? (Mark all that apply):

- No problems in spending allocation
- Delays in signing contracts
- Difficulties in hiring staff
- Space was not immediately available
- Community opposition
- Problems obtaining necessary facility license
- Delays in construction/rehab of facility
- Difficult negotiations with other agencies
- Had to change our original plans
- Other (SPECIFY: ______________________)

For any marked, please explain the nature of the problem:

________________________________________________________________________
________________________________________________________________________

22. What steps have you taken to resolve these problems?

________________________________________________________________________
________________________________________________________________________

23. Do you require the Bronzan funded programs to report anything to you in addition to what the state requires?

YES NO

If yes, what are those reporting requirements?

________________________________________________________________________
________________________________________________________________________

Could you send me copies of any of those reports?
24. Does the county evaluate the activities of individual Bronzan funded programs?

YES NO

If yes, who is responsible for the evaluation?

________________________________________

How often do you evaluate the programs?

___ Quarterly
___ Every six months
___ Annually
___ Only if a problem arises

What does the evaluation entail?

___ Reviewing forms filled out by the programs
___ Site visits (How often?__________)
___ Special studies
___ Checking on complaints
___ Other

IF ANY WRITTEN EVALUATION PROTOCOLS ARE USED ASK FOR COPIES TO BE SENT.

25. How do you decide whether to renew and/or expand funding to individual programs?

________________________________________

________________________________________
26. Does your county provide any training for HMD program directors and staff?

YES  NO

If yes, what kind of training do you offer?

- About mental illness
- About medication side effects
- Techniques for interviewing the mentally disabled
- Techniques for engaging the mentally disabled
- Reporting procedures for the MIS
- Treatment and handling of individuals with dual diagnosis
- Other (SPECIFY:__________________________________________)

Do you believe there is a need for (additional) training?

YES  NO

If yes, what type of training is needed?

__________________________________________
__________________________________________

SPECIFIC PROGRAM ACTIVITIES

Now I would like to ask you about some of the specific programmatic activities taking place in the county. We are particularly interested in programs or approaches that you consider successful or innovative.

27. Does the county fund any outreach activities?

YES  NO---SKIP TO NEXT SECTION

28. Approximately how much is spent on outreach? $____ OR ____ FTEs
29. Where are outreach activities conducted?

○ In the streets, parks, etc. YES NO
○ At jails, police stations YES NO
○ At shelters YES NO
○ At bus stations YES NO
○ At SSI offices YES NO
○ At General Relief offices YES NO
○ VA Administrative offices YES NO
○ Hospital emergency rooms YES NO
○ At other programs serving the homeless YES NO
○ Other (Specify: ______________________)

b. About what proportion of your outreach activity is conducted "on the streets" versus at various offices?
   Streets ____% Offices ____%

c. How many contacts are made in an average day/week/month?____

d. Is the number of contacts being made...
   ___ About what you expected
   ___ More than you expected
   ___ Less than you expected

30. What factors contribute to a successful outreach program?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

31. Do you now have the capability to provide outreach services to
all HMD in your county?

YES   NO

a. If NO, what proportion are unserved? ___%  
Why?
   o Not enough money ---> How many $ needed? $ ___
   o Not enough staff ---> How many staff needed? ___ FTEs
   o Not willing to be reached
   o Other (SPECIFY:__________)

32. Can you estimate the proportion of HMD that are not accepting services on a voluntary basis, even after numerous attempts? ___%:

Can or should anything be done to reach those individuals?

PROBE: Would greater involuntary authority be useful?

30. Does the county fund any case management activities?

YES   NO

a. If YES, what do these case management services include?

   o Crisis intervention only
   o Follow up services (e.g., medications)
   o Regular client need assessments
   o Securing and maintaining entitlements
   o Referrals to housing
   o Advocacy
   o Transportation
o Support services
o Mental health services
o Regular case review
o Other (Specify: ________________________________)

b. Has the nature of case management changed under the Bronzan program?

YES       NO

Please describe:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

31. To what extent have programs been successful in developing service plans for the HMD?

o Do not know
o Developed most of the time
o Developed about half of the time
o Rarely developed
o Never developed
o Other (specify: ________________________________)

32. Do you try to involve family members or friends in the development and implementation of service plans for the HMD?

YES       NO

If yes, to what extent have programs been successful in engaging family members or friends in service plans?

o Do not know
o Engaged most of the time
o Engaged about half of the time
o Rarely engaged
o Never engaged

33. Does the county have crisis residential facilities for the HMD?
   (NOTE: These are usually limited to either 14 or 30 day stays.)

   YES     NO

   If yes, how many beds are available? _____
   Are there enough beds? YES       NO---> How many needed?_____
   What is the average length of stay?_____
   What proportion of individuals are linked to longer term housing arrangements?_____

   If no, does this pose any particular problems?

34. Does the county have transitional residential facilities for the HMD?
   (NOTE: These are usually 1-3 month stay facilities.)

   YES     NO

   If yes, how many beds are available? _____
   Are there enough beds? YES       NO---> How many needed?_____
   What is the average length of stay?_____
   What proportion of individuals are linked to longer term housing arrangements?_____

   If no, does this pose any particular problems?
35. Do you keep statistics on the number of HMD persons placed in permanent housing?
   NO YES—> Please send report.

During the past year, how many HMD persons have been placed in permanent housing arrangements? ________

What barriers, if any have you experienced in arranging for permanent housing?

   o No barriers experienced
   o Obtaining eligibility for SSI or General Relief
   o Inadequate number of beds available
   o Clients do not want permanent placement
   o Individuals do not want to spend money on housing
   o Clients object to restrictions
     (SPECIFY:________________________)
   o Beds not available in areas clients want to live
   o Hard to place certain types of clients
     (Describe:________________________________________)
   o Other
     (Specify:________________________________________)

36. Would you say that coordination in serving the homeless is greater now than it was two years ago?
   YES NO
What activities are you undertaking to improve coordination?

37. In your opinion, has the Bronzan program in your county had any significant effect on:

A. Community awareness of the difference between the general homeless population and the homeless mentally disabled

B. the provision of services by private mental health service providers

C. the approach to treating the HMD by county mental health providers

D. the provision of services by social service agencies

E. the attitudes and support by the Board
of Supervisors

---

F. The police interaction with the HMD

---

38. In your opinion, is your Bronzan program able to:

A. Engage and treat the most severely mentally disabled homeless? 

---

B. Serve the HMD who also have drug and alcohol abuse problems (dual diagnosed)?

---

C. Maintain HMD clients in the system on a long term basis?

---

39. Are there any changes you would like to see made to the Bronzan program?
40. If your Bronzan allocation was increased by 50 percent, how would you spend the additional funds?

OTHER COMMENTS

Thank you for your time in answering these questions. We appreciate the cooperation we have received. I would like to give you this opportunity to add any thoughts or comments you might have about the HMD program that may not have been covered in this interview.
Appendix E

HOMELESS STUDY SAMPLING DESIGN, ENUMERATION, AND SURVEY WEIGHTS

The detailed results of the homeless study sampling design and enumeration are presented in this appendix.

OVERVIEW OF SAMPLING DESIGN

We defined two mutually exclusive sampling strata: homeless persons spending the night in emergency shelters (hereinafter, the "shelter" stratum); and homeless persons not in shelters, but outside in streets, parks, abandoned buildings, all-night theaters or coffee shops, bus and train depots, vehicles, campgrounds, beaches, and riverbeds (hereinafter, the "street" stratum). By conducting the entire survey in a given area on a single night, overlap between the two strata was avoided.

For the shelter stratum, the sampling frame was all shelters in the county. At the first stage, shelters were selected with probability proportional to the number of persons given beds in that shelter on a typical night. At the second stage, adults in the shelter were randomly selected to participate in the interview, with the number of adults selected constant across shelters in a county. In addition, the total number of homeless persons in the shelter on the night of the survey was recorded.

The design of the "street" stratum was more complicated. At the first stage, local experts (generally local police) throughout the county were asked to make estimates of the number of homeless persons who would be found unsheltered overnight in the area of the county that they were most familiar with. These estimates were obtained for each of the census tracts comprising the county. Census tracts were then selected with probability proportional to the estimated number of unsheltered homeless persons in the tract. At the second stage, this procedure was repeated for each census block within the selected census tracts. Blocks were stratified into high-, low-, and zero-density
blocks. All high-density blocks were included in the sample, and low-density blocks were randomly sampled. Each selected block was thoroughly searched at night (generally from midnight until 4 a.m. although the procedure varied somewhat depending on the circumstances). An attempt was made to screen all persons found on the block at this time. If too many persons were present to screen each one, sample individuals were chosen using a random selection strategy. Whether or not individuals were chosen for the sample, all persons in the block were enumerated. Among those who did not complete screening questionnaires for the study (either because they were not selected or because they did not cooperate), a judgment was made as to the likelihood that the individual was homeless.

Below we give results of the sampling and enumeration of the street samples, then those results for the shelter samples.

ORANGE COUNTY STREET SAMPLE

We estimated between 316 and 375 homeless on the streets of Orange County on the nights of the survey. Our upper estimate is close to the one we obtained when we added the estimates of local experts across areas--378 homeless persons.

Orange County contains over 2,000 blocks. Expert judgment holds that the homeless are not uniformly dispersed among the blocks--it is thought that most contain very few (none, in fact), and a few contain very many. The number of blocks we could afford to visit was small. We believed that a simple random sample of blocks would be highly inefficient, so we elected to sample blocks in such a way that blocks thought to contain larger numbers of homeless would have higher selection probabilities.

To sample in this way, we needed preliminary estimates of homeless in each block. Such estimates can be made by various local experts (e.g., police, social workers) in the various areas, but to do so for all the blocks in Orange County would have been too expensive. Therefore, we adopted the following two-stage approach.

- We used local experts to estimate the number of homeless in each of the 418 census tracts in Orange County.
- We drew a sample of tracts and used local experts to estimate the number of homeless in each block of the selected tracts.

- We then drew a sample of blocks from each selected tract.

We selected tracts in the first stage, and blocks within tracts in the second. We discuss each stage in turn.

Of the 418 Orange County tracts, our various experts identified only 51 thought to contain any homeless at all. They estimated that the streets in these 51 tracts contained 378 homeless persons in all, 125 confined to one particular tract (a county campground).

If the expert estimates were perfect, the optimal sample would select tracts with probabilities inversely proportional to the estimates. However, if we believed that the expert estimates were perfect, there would be no need to proceed; we could just use those estimates. After some experimentation, we adopted the following plan:

- Pick the five "largest" tracts with probability 1.
- Pick 4 tracts at random from the next 14.
- Pick 3 tracts at random from the remaining 31.
- Ignore all the tracts thought to have no homeless at all.

This plan was 87 percent as efficient as the plan we should have followed if we believed the expert judgments were perfect. There is in the background the optimal plan—the plan that uses the true counts of homeless. We doubted that the expert judgments were accurate enough to achieve 87 percent efficiency with respect to the true optimum, and so the chosen plan was probably as efficient as any, and it was easier to implement.

We were a little concerned about ignoring altogether the tracts thought to be empty of homeless. This issue is addressed further in our discussion of the Alameda County street enumeration which follows.

Table E.1 shows the total number of tracts estimated by the experts to have at least one homeless person, and Table E.2 shows the sample drawn according to our plan described above.
Table E.1

PLAN FOR SELECTING ORANGE COUNTY TRACKS

Use 5 Tracts with Probability 1

<table>
<thead>
<tr>
<th>Tract</th>
<th>Expert Count</th>
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<tr>
<td>219.07</td>
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Select 4 from These

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Select 3 from These

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Table E.2

THE ORANGE COUNTY TRACT SAMPLE

Selected with Probability 1

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Selected with Probability 4/14

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Selected with Probability 3/31

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</table>
Armed with the tract just described, we obtained expert estimates of the number of homeless within each block of each selected tract. The experts thought some of the blocks would be empty of homeless; consistent with the decision made about tracts we decided not to sample such blocks.

After a little thought, we adopted the following general scheme, described in more detail below. Some blocks were to be selected with probability 1. Others were to be selected with equal probability.

Table E.3 displays a list of the selected census tracts, and within each tract, all the blocks with non-zero estimated homeless population. Within each tract, the blocks are sorted. First, they are sorted into two "priority groups"; priority 0 for blocks with many homeless, priority 1 for blocks with only a few. (In tracts with only one block, that block is given priority 0 regardless of the number of homeless.) Within each priority group, the blocks are sorted in random order.

Because we did not know how many blocks could be covered on a given night, interviewers were instructed to cover each block on the list in the order that the blocks were listed, until they ran out of either time or blocks. We would then compute sampling probabilities conditional on the number of blocks covered after the fieldwork was complete.

We asked the interviewers to make special efforts to cover every priority 0 block, and within each tract at least one priority 1 block.

Now that we have described the sampling plan for the Orange County street enumeration, we turn to a description of the enumeration results. For each block, our interviewers recorded two numbers. First, they recorded the number of "homeless"—the number of people seen in the block who through observation were judged to be homeless or who were approached and asked some questions that verified that they were homeless according to the project definition of that term. Second, they recorded the "possibly homeless"—the number of people seen on the street who "looked" homeless, but whose homeless status could not be verified. (A number of people were also seen on the street who were judged without the interview as "not homeless," for example, when seen entering their Mercedes.)
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The campground, tract 219.07, contained too many camping spots to be visited, so the interviewers drew a random sample of 39 out of the 119 possible.

Table E.4 shows the details of the estimate. It displays only the sampled blocks where any homeless (or "possibly homeless") were found. An additional 29 blocks were included in the sample and searched, but no homeless were found.

In Table E.4, the columns headed "Count" give the number of individuals who were verified homeless by a direct question, and the additional number of "possibly homeless." Estimates are obtained by multiplying the counts by the sampling weights. The columns headed "Estimate" give nominal and high estimates of the homeless street population in each tract obtained from the block counts. The nominal estimate uses the number of verified homeless; the "high" count includes in addition the "possibly homeless."

Table E.4 also displays the total number of adults counted, and among these, the number selected for the survey questionnaire. Weights for this sample, unadjusted for nonresponse, are given in the last column. These unadjusted weights were applied to survey questionnaire data to ensure that they would represent all homeless adults in the sampling frame; however, they were not relevant for the estimated counts of the homeless.

ALAMEDA COUNTY STREET SAMPLE

In Alameda County, we conducted two enumerations at different times. The second enumeration was planned when our field experience during the first enumeration suggested that we had failed to include in our sample some areas in which homeless persons could be found. In our first enumeration, we counted between 297 and 336 homeless on the streets of Alameda County on the nights of the survey. Our lower estimate exceeds that of the combined local experts (192 homeless) by a rather substantial margin. These counts were essentially a census—we counted the homeless in every block in which local experts said homeless could be found. In our second enumeration, we estimated an additional 200 to 212 persons in the streets in previously unsearched
Table E.4

ORANGE COUNTY STREET SAMPLE ESTIMATES

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|           |           |      | Verified + Verified |          |
|           |           |      | Adults Interviewed | Unadj. Weight |
| 165       | 183       | 38   | 17               | 6.82        |
| 0         | 4         | 0    | 0                |
| 0         | 0         | 0    | 0                |
| 33        | 37        | 18   | 2                | 2.50        |
| 3         | 3         | 3    | 2                | 1.50        |
| 1         | 1         | 1    | 1                | 1.00        |
| 44        | 55        | 43   | 10               | 4.30        |
| 37        | 37        | 37   | 11               | 3.35        |
| 15        | 15        | 15   | 4                | 3.75        |
| 2         | 2         | 2    | 1                | 2.00        |
| 4         | 4         | 1    | 1                | 3.50        |
| 2         | 2         | 1    | 1                | 2.43        |
| 0         | 11        | 0    |                   |

Total 316 375
areas of Alameda County. These estimates are based on a two-stage sampling design, which is described in further detail below. Respondents were sampled for the survey interview as part of the first enumeration. The second enumeration consisted only of counts of homeless persons, and survey interviews were not conducted.

First Enumeration
All census tracts in which local experts said there were any homeless, and all such blocks within these tracts, were surveyed, so the first Alameda County counts are based on an exhaustive count, not a sample. Table E.5 presents the counts for those blocks in which any homeless were found. An additional 54 blocks were searched in which no homeless were found.

In each block, a sample of adults was selected for the questionnaire. The sampling weights for this subsample, unadjusted for nonresponse, are given in the last column of Table E.5.

Second Enumeration
While conducting the first enumeration and survey, our field supervisors noticed homeless persons in a number of areas that had not been mentioned by local experts as areas in which homeless persons could be found. As a result, we began to suspect that our initial coverage of local experts had not been thorough enough. We recontacted local experts, talked to additional persons we thought would be knowledgeable of the homeless population in Alameda County, and as a result of these contacts, decided that in our first enumeration we had excluded too many areas that may have had homeless persons.

The second enumeration was a sample of tracts and blocks from new areas that could have homeless persons. As in Orange County, the sample was drawn in two stages. At the first stage, all tracts in Alameda County that had not been searched as part of the first enumeration were divided into three categories of tracts, based on our further information from local experts and on our previous field experience: "Probable" tracts (those experts thought would probably have at least one homeless person), "possible" tracts (those which possibly had a
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<td><strong>297</strong></td>
<td><strong>39</strong></td>
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</table>
homeless person), and "zero" tracts (those in which a homeless person was very unlikely to be found). All 16 "probable" tracts were selected for the sample, plus 13 of 116 "possible" tracts.

In addition, we selected 7 "zero" tracts, distributed throughout Alameda County cities. For efficiency in the field, the "zero" tracts were selected to be adjacent to other sampled (possible and probable) tracts. The inclusion of "zero" tracts in the enumeration differed from our previous strategy of excluding zero tracts from the sample, and was meant to be a check on our assumptions about the "zero" tract areas for all the counties.

At the second stage, blocks within probable and possible tracts were divided into priority 0 blocks and priority 1 blocks. Blocks with priority 0 were those that experts had mentioned specifically as areas within the tract that homeless persons might be found. Each of these blocks was included in the second enumeration. A random sample of the priority 1 blocks within each tract was also included.

Table E.6 shows the details of the enumeration among the "probable" and "possible" tracts, for all blocks in which homeless persons were found. It gives the counts of homeless, the weights at the tract and block level for the estimates of the numbers of homeless, and the resulting estimate of the numbers of homeless. An additional 106 probable and 43 possible blocks were searched in which no homeless individuals were found.

We also selected, just in Alameda County, some blocks in tracts that experts thought had no homeless at all ("zero" estimate tracts). Among 7 "zero" tracts in Alameda County, 17 blocks were randomly selected and searched. In one block, one homeless person was found. In another block, one individual was seen who might have been homeless, but this could be verified. Because a large number of tracts (114) were classified "zero" tracts in Alameda County, finding these two individuals in 17 blocks suggests that 130 to 244 individuals could be found across all the zero tracts in Alameda County.

As part of the second enumeration in Alameda County, we also re-enumerated some blocks that had been searched in our first enumeration, to get some idea of the stability of our prior estimates.
### Table E.6
SECOND ALAMEDA STREET SAMPLE ESTIMATES

<table>
<thead>
<tr>
<th>Tract Type</th>
<th>Tract No.</th>
<th>Block No.</th>
<th>Number of:</th>
<th>Weights</th>
<th>Estimate</th>
</tr>
</thead>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Verified</td>
<td>Possible</td>
<td></td>
</tr>
<tr>
<td>Probable tracts</td>
<td>4220</td>
<td>130</td>
<td>5</td>
<td>0</td>
<td>1.00</td>
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<tr>
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<td>307</td>
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</tr>
<tr>
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<tr>
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<td>4029</td>
<td>104</td>
<td>0</td>
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<td>1.00</td>
</tr>
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<td>4029</td>
<td>104</td>
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<td>1.00</td>
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<tr>
<td>Possible tracts</td>
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<tr>
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<td>302</td>
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<td>0</td>
<td>8.92</td>
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<tr>
<td>Total</td>
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</table>
Fourteen blocks were included in the re-enumeration. Whereas 92 individuals were counted in the first enumeration, only 49 were counted the second time. There are two possible explanations for this decline: 1) Homeless individuals may frequently move from one area to another, so that the stability of an estimate over time for one particular area is low; and 2) the size of the street population declined from late October (when the first enumeration was conducted) to early January (when the second enumeration was conducted). The first explanation is generally more compelling to us, and is consistent with our general strategy in these counties, which was to widely cover the areas in which these individuals would potentially be found.

YOLO COUNTY STREET SAMPLE

In Yolo County, just as in the first Alameda enumeration, all census tracts in which local experts said there were any homeless, and all such blocks within these tracts, were surveyed, so Yolo County blocks were exhaustively counted, not sampled. Table E.7 presents the counts for those blocks in which any homeless were found. Thirteen additional blocks were searched in which no homeless were found. In each block, a sample of adults was selected for the questionnaire. The sampling weights for this subsample, unadjusted for nonresponse, are given in the last column of Table E.7.

SHELTER SAMPLES

For the shelters in each county, the enumeration was less complex than for the street samples. In Orange and Alameda counties, a sample of shelters was first drawn, and then within each sampled shelter a sample of adults was selected for the questionnaire. The shelters were sampled with probability proportional to the number of beds we were told were in the shelter, and our original goal was to select a fixed number of homeless in each sampled shelter. Such a sample would have been self-weighting. For a number of reasons, we were unable to draw a fixed sample size in each shelter, so the resulting weights are not constant over the shelters. In Yolo County, only two shelters for the homeless were found, and each of these was surveyed.
Table E.7

YOLO COUNTY STREET SAMPLE ESTIMATES

<table>
<thead>
<tr>
<th>Tract No.</th>
<th>Block No.</th>
<th>Verified Homeless</th>
<th>Possible Homeless</th>
<th>Possible + Verified</th>
<th>Total Adults</th>
<th>Adults Interviewed</th>
<th>Unadj. Weight</th>
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</table>
Table E.8 presents the results for all three counties. For the sampled shelters, it shows the number of beds we were told each shelter contained, the number of homeless we found in each shelter (both adults and children), and the number of homeless adults. The column headed "Shelt" gives the shelter specific weight, the column headed "Pers" gives the within-shelter weight to be assigned to each surveyed adult, and the column headed "Joint" gives the product of the two—the weight to be used for each surveyed adult in the shelter.

In several shelters the actual number of beds was different from the original estimate. This actual number is displayed in the column headed "Act." Since the reported number was used for sampling, we used it for computing the sample weights. Our estimate for the total number of homeless and the number of homeless adults in each county is derived as a fraction of the actual number of beds, the fractions being estimated from the sampled shelters.

In Alameda County, an additional four shelters were identified after the survey was completed, with a total of 67 beds across the four shelters. These beds were added to the estimate of the number of homeless in the shelter sample.
### ESTIMATES OF THE SHELTERED POPULATION

#### Orange County

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<thead>
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<th>Shelter ID</th>
<th>No. of Beds</th>
<th>No. of Persons</th>
<th>No. of Adults</th>
<th>No. of Adults Interviewed</th>
<th>Weights</th>
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#### Alameda County

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<th>No. of Persons</th>
<th>No. of Adults</th>
<th>No. of Adults Interviewed</th>
<th>Weights</th>
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<td>30</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>14</td>
</tr>
<tr>
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<td><strong>58</strong></td>
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<td><strong>305</strong></td>
<td><strong>285</strong></td>
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#### Yolo County

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<th>No. of Persons</th>
<th>No. of Adults</th>
<th>No. of Adults Interviewed</th>
<th>Weights</th>
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</thead>
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</table>
Appendix F

HOMELESS SURVEY FIELD PROCEDURES

This appendix describes in detail the procedures for conducting the survey of homeless persons in three counties. The RAND Survey Research Group conducted the fieldwork.

This appendix describes:

- The collection of information needed to design the samples of shelters and street areas in which homeless individuals were enumerated and interviewed
- The pretest of the survey questionnaire and methods of searching for and approaching homeless individuals
- Selection and training of interviewers
- Performance of the survey and enumeration
- Survey completions and nonresponse
- Data handling

COLLECTION OF INFORMATION TO DESIGN SAMPLES

Information regarding the quantity and location of homeless individuals in emergency shelters, on the streets, or at other nonshelter locations was needed to design the shelter and street samples for the enumeration and survey of the homeless. This information was collected from service providers, county workers, public officials, and police officers. Resource guides, such as the California Homeless Shelter Provider Directory (published by the Department of Housing and Community Development Emergency Housing Program) and short-term housing directories (published by both service providers and community volunteers), were used to develop contact lists.

All known county shelters were contacted by telephone to determine the number of beds, types of homeless persons served, and the number of people served daily. In addition, contacts with local experts (including police, shelter providers, and mental health staff) were made
to get estimates of the numbers of homeless persons who stayed unsheltered overnight in every census tract in each of the counties.

This overview of the numbers and location of each county’s homeless population and numbers of beds was carefully charted by census tract on census tract maps, and sampling lists were generated. From these data, analysts selected a sample of shelters and a sample of census tracts (see details in App. E).

The next stage of the sampling design process was to describe each of the census tracts selected for the street sample. Census tract blocks, sometimes covering several city blocks, were assigned an expected number of homeless sleeping on the streets on any given night, based on further discussions with local experts. When contacting people, we had city maps and census block maps in front of us to visually guide the contact person through each block so as not to overlook potential locations. Information was cross-checked with several individuals and/or other organizations. When discrepancies occurred in estimated figures, an average of the judgments was used.

After block-level estimates were completed, blocks were selected for the enumeration and survey of homeless persons by the analysts (see details in App. E).

PRETEST

A pretest to the survey of homeless persons was conducted to test the screener and questionnaire for their effectiveness, to evaluate the field procedures (such as interviewer training techniques, searching and walking blocks, spotting areas of potential difficulty for interviewers), and to evaluate adequacy of study protection of human subjects. The Venice area of metropolitan Los Angeles and the City of Santa Monica, with a combined total population of approximately 125,000, were chosen to conduct the pretest. These locations, in close proximity to RAND, have a significant number of people without homes. There is not a visible stereotyped skid row; the area required interviewers to search to find the scattered singles and groups of homeless who were sleeping on the beaches, parks, alleyways, storefronts, and on the streets.
The pretest was conducted by the director of field operations, the field supervisor, and a trained interviewer. One of the 7 shelters for homeless in the area was selected as a pretest site. A total of 19 interviews were conducted; 11 in shelters and 8 in street areas. Two additional people were approached on the street and completed the screener but they were determined not to be homeless; one more was approached who appeared homeless but did not speak English. Two people refused to participate; one in the shelter sample and one in the street sample. Street interviewing was conducted late at night when the streets had less general foot traffic and when many homeless were bedded down for the night. This timing enabled the interviewers to more quickly identify homeless people and minimize the possibility of double enumeration. The interviewers were accompanied by a plainclothes off-duty police officer.

The pretest provided information that assisted field design and strategy. An important criterion and concern in our approach was that it be nonthreatening to people. The introduction to the study was found to elicit the interest of the homeless; they were willing to listen. We were able to awaken people without bringing about a fearful reaction. We explained the nature of our inquiry, explained the voluntary nature of the study and answered any questions. The vast majority of people were responsive to our questions and completed the questionnaire.

We determined that the length of the questionnaire met our expectations from the standpoint of respondent burden and budget considerations (average interview time was 22 minutes). During the pretest debriefing sessions, some questions were worded and reformatted to aid both the respondent and interviewer in focusing on the time period in question and the subject matter. The screener was amended so that interviewers could more quickly establish whether a respondent was eligible for participation. These changes enhanced the effectiveness and efficiency of the instrument.

We wished to eliminate any coercion that respondents might feel. We observed and were satisfied that indeed respondents felt reasonably at ease, even with a police officer present. Respondents were pleased
to receive payment of $2 for the pretest ($1 for the screener and $1 for the interview). Based on recommendations from the RAND Committee on Human Subjects Protection, we increased the payment to $3 for the interview ($4 for both screener and interview) for the main study.

The selected areas were walked in advance by the field director and field supervisor during daytime hours to map out possible sleeping spaces and areas that might be overlooked in the dark. The interviewers were then given detailed maps of the area. This proved to be an effective planning procedure, which was used in the main study.

The process of counting homeless persons and keeping records of these counts was found to be adequate for gathering accurate information.

It became increasingly clear throughout the pretest that many specific issues, such as how to traverse a block and how to encourage someone to participate, would need to be incorporated in detail into the training agenda. (Interviewer training is discussed in detail below.)

When unexpected events arose in the pretest, we noted that they were bound to occur in the main study. For example, the itinerary was carefully planned, but one of the two scheduled police escorts at the last minute was not available. We were able to rearrange our schedule and conduct the street interviews with only one escort. As a result of this experience, additional precautions were taken in the main study to confirm, reconfirm, and if necessary have alternative police escort arrangements.

The questions that the off-duty police escort asked the interviewers during the pretest became the core of the standard escort orientation for the main study. The officer’s observational skills and ability to assess potentially risky situations were quite helpful. (Escort orientation procedures are discussed below.)
SELECTION AND TRAINING OF INTERVIEWERS

Recruitment and Selection

In an effort to minimize costs and maximize quality, we decided to use the same staff of interviewers, hired in Los Angeles, for all three county sites. The costs of transporting one team of interviewers to the two distant sites (Alameda and Yolo) were offset by the costs which would have been incurred in hiring and training interviewers off-site.

The field supervisor screened 225 resumes and applications; approximately 35 were interviewed on the phone and 22 were asked to participate in group interviews which were conducted by the field director and field supervisor.

Group interviews provided an arena in which the applicant could demonstrate his/her interpersonal skills, describe relevant experience, disclose biases, and display attitudes and facility in a social interaction. These were important considerations which were relevant to hiring interviewers for this study. In addition, each candidate was observed in a group interview session for ability to contribute to a team effort.

Of the 22 final candidates, 6 people were hired to go through training (5 men and 1 woman). It was anticipated that thorough and demanding training would provide a further screening process through which all candidates might not pass. Therefore, each trainee was advised that successful completion of the training program was prerequisite for participation as an interviewer in the study.

Two trainees had worked on previous RAND studies, and four had either background in social science research or experience in general interviewing. All trainees had demonstrated facility in talking with people, flexibility, intelligence, respect for the procedures of a structured interview, and had showed vitality, professionalism, diligence, and compassion for the task at hand.
Training

Interviewers were trained in a comprehensive and challenging four-day program which emphasized: developing skills in conducting a structured, objective interview; becoming familiar with sensitive approaches to interacting with homeless and mentally disabled persons; learning detailed procedures and roles for enumerating and searching for homeless persons; and becoming comfortable with encouraging the participation of respondents.

Expecting that our work in the streets and in the shelters would include interviews and interactions with people who might be mentally disabled, we asked Greer Sullivan, M.D., a psychiatrist at UCLA who has had extensive experience treating the severely mentally ill, to talk about these issues to the trainees. Conducting a structured interview with a mentally ill person posed unique difficulties. Dr. Sullivan's discussion included characteristics of the affect, interactive, and thought processes of schizophrenics. The need to focus the attention of the respondent, techniques for doing so, and the knowledge that in many instances, with patience, a questionnaire can be fully completed, was information which was encouraging, informative, and useful.

Dr. Paul Koegel, an anthropologist at UCLA who has completed a study of the homeless of Skid Row in Los Angeles, talked with interviewers about the homeless population, emphasizing the need for approaching the respondent with respect and appreciation for his/her participation in the study. He was encouraging in describing the high completion rate of the Skid Row study, and explained that the vigilance, alertness, and other typical behaviors that interviewers might encounter are adaptive behaviors of the homeless which are an outcome of living on the streets.

Quality data collection is derived from interviewers who know the importance and purpose of the questionnaire, understand the care which is put into the design of the instrument, and appreciate the roles of both the interviewer and respondent in this interactive process. Thus, each of these points was addressed in detail during training by Audrey Burnam, Ph.D., Research Psychologist, and Judy Perlman, M.A., Field
Director; each comes from a background of extensive training experience in major mental health and health studies.

The entire questionnaire was repeatedly practiced using didactic training exercises, short mock interviews, and role plays. Homework and in-class assignments were given. A section of the questionnaire, adapted from the Diagnostic Interview Schedule, was used to diagnose schizophrenia. It required specific training in its precise, complex, and highly structured probing patterns, and required interviewer judgment of examples of delusions and hallucinations to ensure that the intent of the question was met. Special attention was given to this section in the training, and interviewers learned to probe and make appropriate judgments to our satisfaction.

The last day of instruction included discussion of the police escort's role, examples of a typical night's schedule, principles of enumeration and sampling in streets and in shelters, and practice with introducing the study to potential respondents with the goal of allaying concerns and encouraging participation in the survey.

Interviewers were judged by their ability to make a positive and professional connection with a respondent, their understanding of the interview and the intent of the questions, their ability to listen carefully to responses to determine that the intent of the questions was met by the response, their ability to complete an entire questionnaire with a high level of accuracy, and their ability to demonstrate through training and role playing that their participation would be an asset to a team effort. We observed each trainee and discussed his or her concerns and attitudes in order to be reasonably confident that those we chose could adapt to the late hours and demanding work environment.

Interviewers received feedback each day about their progress. Their practice interviews were reviewed by the field director and supervisor and discussed in class, when appropriate, as part of the review. Five of the six interviewers were offered positions with the study, and each one enthusiastically accepted.
PERFORMANCE OF THE SURVEY AND ENUMERATION

Overview of Field Operations

The enumeration and the sample surveys of the homeless were made at night over a two- to five-day period, depending on the size of the county. In each county, four to five interviewers and two field supervisors visited a sample of shelters and searched selected census blocks to count the homeless. In the census block search, each interviewer was accompanied by a police officer to assist the search and ensure safety. In both shelters and census blocks, all homeless individuals were enumerated, and a random sample of these were selected for the survey.

Prior to the fieldwork, the field supervisors visited and mapped each selected census block during the day and made arrangements to visit each selected shelter. Preceding each evening of fieldwork, the interviewers and police escort were briefed by the supervisors on the evening schedule and about any difficult areas to be anticipated. The teams carried walkie-talkies and remained in continuous contact with the field supervisors.

The homeless enumerations and surveys took place the week of September 15, 1987, in Orange County; the week of October 19, 1987, in Yolo County, and the week of October 25, 1987, in Alameda County. A second enumeration of Alameda County, which did not include a survey of homeless individuals, was conducted the week of January 11, 1988.

Preparation for the Enumeration and Survey

To prepare for the shelter enumeration and survey, selected shelters were contacted for permission to conduct the survey on-site for several hours in the evening. Introductory letters were written explaining the general purpose and procedures of the study. Care was taken to explain the importance of random sampling procedures, as many administrators suggested that it might be helpful for them to "sign up" participants prior to our arrival.
Site visits were made by the field director to each selected city, and maps of each area were sketched. The maps included relevant notes about census blocks, describing, for example, areas with well-lit businesses, industrial and residential areas, and areas of undeveloped fields or abandoned buildings. The maps were used by the field director in scheduling assignments based on the profile and terrain of the area, and in briefing the interviewers for the search, enumeration, and interview process.

A tentative scheduling of each night's work was established after the initial site visits. Decisions were based on geographic considerations such as the amount of territory that needed to be covered, driving time, and proximity of one city to the next. The goal was to be as efficient as possible and to prevent double enumeration of homeless persons who might move to various parts of a city from night to night, or go from a shelter to an adjacent street area from one night to the next. Particular consideration was given to attaining a representative picture of the shelter and the street sample around the shelter on a given night to avoid double counting. Work was scheduled in the shelter in early to mid-evening (whenever the doors closed) and on the streets from about 11:00 p.m. to 4:00 a.m.

Police Escorts

We felt assured that escorts were not needed for shelter interviews. This was confirmed by our pretest experience and proved to be true throughout the main study.

However, for interviewing and enumerating the street sample, each interviewer was accompanied by an escort. In most instances, neither the field director nor the field supervisor had an escort, since they were either in an automobile or joined with another interviewer/escort team.

Escorts came from a variety of sources. Whenever possible, police were from the area in which we were interviewing. Although most of the escorts were off-duty officers (28), some were on-duty (9). One on-duty officer created some delays for our fieldwork when he had to respond to
emergency calls (three times in one night). Some escorts were assigned through their commanding officers, some worked through agencies which used off-duty police officers. In one area, it was necessary to use a private security agency, as no local officers were available. Most of the escorts were men (37 male, 4 female).

Out of 41 escorts, 40 were armed, 5 were uniformed. We requested the officers not to wear uniforms to avoid any perception of coercion by respondents, and we generally found officers who were willing to work without uniforms. In one area, however, the local police force required that we be accompanied by uniformed police escorts and ride in police cars.

An orientation was conducted with each escort. We felt that we could maximize the motivation and efficiency of all officers and set the tone for the attitude and approach that we wanted if we could engage each police officer in a detailed orientation before going into the field each night.

The orientation, generally given by the field director, occurred one-half hour before going into the streets. We met at either a police station, a hotel room, a room in a shelter, or in the street. All officers were briefed on some of the important health and civil justice research in which RAND has been involved. Specific information about this study of the homeless, its purpose, and its funding by the State Department of Mental Health was given. The questionnaire was then described as a structured interview with the same questions being asked to each respondent. The purpose of the screener to determine eligibility for the study was explained, as well as the need for the interviewer to take a couple of minutes after the interview to complete an observations section of the survey. Samples of the questionnaire were available for the escorts to review.

The next phase of the orientation process was to delineate what we expected the escorts to do. It was explained that they were being asked to work in a collaborative effort alongside the interviewers to search areas such as stairwells, parked cars, abandoned houses, behind bushes, and anywhere else where people could hide.
Escorts were instructed that they would be awakening respondents, in which case we requested that they be awakened gently, their fears allayed and our intent related immediately. We informed the officers that we intended to meet the homeless people with respect and with appreciation for the time and information which the respondents were giving us, and that we expected the escorts to approach the interaction in the same nontreating manner.

The last phase of the orientation included the enumeration process. Because the interviewer was expected to be engaged in an interview, the escort's role was to observe people on the block and to mark tallies on a Block Enumeration Form. These tallies provided a count of people and recorded whether they appeared to be homeless or not. The escort also recorded this information as the team searched the block. Escorts were asked to hold the respondent payments and to record the identification number and block number where payment was made. (One group of police officers was not permitted by their commanding officer to handle any cash; in this case the interviewer took care of this procedure.)

The escorts varied in their effectiveness in the field. Some did not take the lead when approaching dark alleys or parked cars; some walked too slowly at first, but then began to model the pace of the interviewer. Most officers were interested, helpful, compassionate, thorough, and patient. In some cases the escorts quietly warned us to stand further back from a reluctant respondent or told us to cease trying to ask a potential respondent to participate. Some walked with us in the rain, or led the way into an abandoned building and called ahead to forewarn (and not alarm) anyone present that he was with two people who wanted to talk to them for money. Escorts enumerated as we walked and as we sat interviewing a respondent. They instructed us about how to approach a person walking toward you (start talking while you are a distance away and do not block their way), and how to pay respondents surreptitiously so they would not be accosted later for the money.
We received many comments from officers that the experience was interesting and enlightening for them. One officer said that very late one night he came across a clean, dry basement which was empty. He wished that he could have told a few street people where it was.

Obviously, the escorts were also asked to assure our safety, and we asked for their advice when they felt that we were in or about to enter into a situation or place where we should not be. However, we did confirm that our purpose was to interview the mentally disabled, so apparent mental disorder should not preclude our interaction with this group.

Random Selection of Survey Respondents

For the street sample, interviewers were assigned to a group of blocks which they could walk, search, and interview within a given time period. Generally, when on a low-density block (one on which only 0-3 respondents were expected), interviewers were instructed to search the entire block and screen and interview everyone. When few individuals were found, everyone seen was asked to participate in the survey, and no random selection occurred.

In most cases, we could not be expected to screen and interview every homeless person on a high-density block. Instructions were to enumerate all and interview a sample from the entire block (rather than, e.g., interview people on only one side of a block). Additionally, if a group of people were standing together, one or two respondents were randomly chosen by using a table of random numbers.

For the shelter sample, the administrator of each shelter was asked, upon our arrival, the number of beds and the number of men, women, and children present that night. This information was entered on a Shelter Enumeration Form. When it was not possible to interview everyone in the shelter, respondents were randomly selected from a list of residents (if available), or a room number was randomly selected and a respondent (if more than one) in that room randomly selected. Occasionally, the selected respondent might have left the shelter on an errand and not have returned while the interviewers were there. This was considered a nonresponse; these individuals were not replaced.
In some cases, a motivated administrator had previously asked residents to volunteer for the study. We then explained the need to randomly sample the residents, and this was generally accepted. In a few cases the administrator told us that many people had refused to be interviewed. The field director then asked the administrator if she would be permitted to present the study to the residents and address their concerns. This was effective in converting many possible refusals in shelters.

Supervision in the Field

Contact with each team was maintained through the use of walkie-talkies. Each team was given its assignment of blocks at the beginning of the evening. Because we could not determine the length of time a team would spend on its blocks, additional blocks (randomly sorted) were assigned through walkie-talkie contact as the original assignment was completed.

In addition, walkie-talkies were useful to verify procedural questions when an unexpected situation arose, to call for assistance when more respondents than anticipated were encountered on a block, to monitor the night's progress, and to facilitate the feeling of connection to the larger group of interviewers.

Debriefing sessions were held at the end of each night's work (around 5:00 a.m.). Field supervisors met in a group with the interviewers to review the night's work, share experiences, and to nurture and maintain field staff morale.

Searching for Homeless Persons

In the street sample, interviewers were instructed to search all areas where someone could be staying or sleeping (railroad cars, abandoned buildings, a sheltered overhang behind a church, holes in fences around a school, a dirt road behind a cement factory near a social service building, etc.). In one case, during a daytime drive, the supervisor found a series of abandoned houses marked for demolition, which appeared to be an ideal place for homeless people to find shelter.
When we went there one week later to search and interview, we found the entire area blocked off by an 8-foot fence with guards behind the fence. Despite this exception, the preliminary block overview was useful in anticipating the conditions to be found in the area and the particular places in which homeless individuals might be found.

Interviewers looked in parked cars, and searched among bushes in parks, in coves along the beach, and along the Sacramento River to find camouflaged shelters. We looked under freeway overpasses, in a discarded box lying in an empty field (and found someone wrapped in plastic and cardboard), in closed subway stations, behind bushes, in a church colonnade, in public restrooms, in a parked bus, and in abandoned houses.

Survey Protocol--A Typical Approach

Sleeping respondents were awakened by our speaking or calling to them in an audible (but not shouting) tone. We were careful not to shine a flashlight directly at the face. A typical greeting was: "I'm sorry to disturb you, but I'd like to ask you some questions. You don't have to participate, this is voluntary, and I'll pay you for your time."

We then addressed any questions the respondent might have, introduced the police officer by first name, and, after gaining the homeless individual's consent, began the interview.

Although a few respondents refused to participate or refused to come out from under their blankets, most agreed to answer our questions and many were grateful for our taking the time to ask them questions which they felt were important. More than a few thanked us for caring.

It appeared that respondents were generally candid and answered to the best of their recall. Generally, they did not appear to be affected by the presence of the plainclothes police officer. In at least one instance, however, a respondent refused to reveal drug history because the "cop" was standing right there (although out of hearing range).
Closing the Interview

At the close of the interview, each respondent was given a paper which gave them the RAND telephone number and instructed them to call (collect) if they wanted to contact RAND about the study. On the reverse side of the paper was a referral list of shelters, drop-in centers, and other resources listed by city in the county in which the survey was being conducted. This was accepted gratefully and with interest by many respondents.

SURVEY COMPLETIONS AND NONRESPONSE

Across the three counties, a total of 315 homeless adults completed the survey interviews. As Table F.1 shows, the largest proportion of these were completed in Alameda County (60 percent), and the smallest in Yolo (12 percent). About 38 percent of the interviews were completed with persons who were in shelters at the time of the interview. The remaining interviews were conducted in the "street" areas.

We calculated acceptance rates as the number of persons completing the survey divided by the number selected for the sample. Acceptance rates for the survey were high relative to surveys of household populations. Table F.2 shows acceptance rates by county for shelter and street samples. Only one shelter selected for the study refused to cooperate; this was a shelter with 25 beds for families and children in

<table>
<thead>
<tr>
<th>Interview Location</th>
<th>Across All 3 Counties</th>
<th>Alameda</th>
<th>Orange</th>
<th>Yolo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shelters</td>
<td>121</td>
<td>70</td>
<td>45</td>
<td>5</td>
</tr>
<tr>
<td>Streets</td>
<td>194</td>
<td>118</td>
<td>44</td>
<td>33</td>
</tr>
<tr>
<td>Total</td>
<td>315</td>
<td>188</td>
<td>89</td>
<td>38</td>
</tr>
</tbody>
</table>
Table F.2

SURVEY ACCEPTANCE RATES
(In percent)

<table>
<thead>
<tr>
<th>Location</th>
<th>Across All 3 Counties</th>
<th>Alameda</th>
<th>Orange</th>
<th>Yolo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shelters</td>
<td>92</td>
<td>94</td>
<td>90</td>
<td>83</td>
</tr>
<tr>
<td>Streets</td>
<td>81</td>
<td>86</td>
<td>72</td>
<td>77</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>89</td>
<td>80</td>
<td>78</td>
</tr>
</tbody>
</table>

Orange County. The acceptance rates shown in Table F.2 are for the sampled individuals among the 12 shelters agreeing to let survey field staff enter the shelter and recruit study participants.

Nonresponse was primarily due to refusals to participate. Only three respondents did not complete interviews because they were judged to be too impaired (for example, intoxicated or disoriented).

DATA HANDLING

Confidentiality procedures were carefully maintained. Each questionnaire was coded by an identification number. No names or other information that would link a specific individual to a questionnaire were recorded.

Questionnaires were shipped by an express service from the field to RAND. Materials were logged and edited according to preset specifications by trained RAND data editors. Production reports were generated by the Survey Research Group using dBaseIII, and then passed on to the analysts.

Data were keypunched and transferred to a computer data disk. Data were checked for out-of-range and inconsistent responses, and discovered errors were corrected by consulting the original questionnaire.
Appendix G

SHORT SCREENER FOR MENTAL AND
SUBSTANCE USE DISORDERS

The survey included 24 questions which screened for lifetime diagnoses of DSM-III major affective disorder (including bipolar affective disorder and major depression), schizophrenia, drug abuse or dependence, and alcohol abuse or dependence. The mental disorder screener was developed specifically for this study. It is a set of questions taken from the Diagnostic Interview Schedule (DIS) (Robins et al., 1981). The screener took approximately 10 minutes to administer, and required special training of interviewers who learned to use a sequence of probes when symptoms of schizophrenia were observed.

The DIS is a very detailed and highly structured survey interview which can be administered by trained lay interviewers. The information collected with the DIS can be scored using a computer algorithm to obtain DSM-III lifetime and current diagnoses. The DIS displays adequate reliability and validity for research purposes (see review by Burk, 1986), and has been used in several large-scale population studies sponsored by the National Institute of Mental Health (Regier et al., 1984). However, the DIS is much too lengthy (about an hour) to have been used for our study of the homeless, particularly because individuals were to be interviewed in the middle of the night.

We developed the mental disorder screener by selecting key DIS items for the DSM-III disorders of interest, and choosing a brief combination of those items which were likely to be highly predictive of the diagnoses obtained when using the full DIS. The ability of the screening form to detect homeless individuals with the full DIS/DSM-III diagnosis was then tested using survey data previously obtained in a sample of 328 homeless from the downtown Los Angeles Skid Row area. In this L.A. Skid Row study (Farr et al., 1986), the full DIS was administered. Several alternative screening item combinations were examined using these data. We chose the alternative which resulted in a low rate (20 percent or less) of misclassifying persons who were truly
mentally disordered (false negative errors), and at the same time minimized the likelihood that we would incorrectly classify someone as mentally disordered when in fact they were not (false positive errors). When we had to trade off between choosing more false negative errors or more false positive errors, false positive errors were considered more acceptable.

Table G.1 shows the sensitivity, specificity, and positive predictive value of the screening items when the lifetime DSM-III diagnoses obtained from the full DIS are considered the criteria or "true" diagnoses. Sensitivity is the proportion of true positive cases correctly classified by the screener; specificity is the proportion of true negative cases correctly classified by the screener; positive predictive value is the proportion of cases classified positive by the screener that are true positives.

As this table shows, the screener was highly predictive of disorders that were assessed using the full DIS. However, the screener did result in some misclassification errors. For substance use disorders, misclassifications (both false positive and false negative errors) were very infrequent. But for the severe mental disorders, defined in our study as schizophrenia and major affective disorder,

Table G.1

ABILITY OF THE MENTAL DISORDER SCREENER TO DETECT DIS/DSM-III DIAGNOSES

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Predictive Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe mental disorder</td>
<td>91</td>
<td>67</td>
<td>52</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>98</td>
<td>92</td>
<td>66</td>
</tr>
<tr>
<td>Major affective disorder</td>
<td>88</td>
<td>70</td>
<td>42</td>
</tr>
<tr>
<td>Substance abuse/dependence</td>
<td>96</td>
<td>84</td>
<td>96</td>
</tr>
<tr>
<td>Alcohol</td>
<td>94</td>
<td>85</td>
<td>91</td>
</tr>
<tr>
<td>Drug</td>
<td>89</td>
<td>99</td>
<td>97</td>
</tr>
<tr>
<td>Dual (mental and substance)</td>
<td>84</td>
<td>74</td>
<td>45</td>
</tr>
</tbody>
</table>
almost half of those identified as disordered by the screener did not have a positive diagnosis.

Table G.2 shows the weighted percentage of homeless persons in each of the three counties in our survey who were classified positive using the mental disorder screener. It also shows the comparable percent of screener positive cases when the screener algorithm is applied to the homeless in the L.A. Skid Row study. The true rates of mental and substance use disorders were estimated in Sec. III. Those rates were adjusted for the likelihood of the screener to misclassify by assuming similar false positive and false negative rates across the homeless populations in L.A. Skid Row and the three counties.

We can compare the percentages of homeless screened positive for severe mental disorder in Table G.2 with the percentages estimated to truly have severe mental disorder (Sec. III, Table 3.3). For the substance use disorders, the percentage of persons screened positive and the percentage estimated to be truly positive are very similar. For severe mental disorder, the proportion who were positive on the screener is substantially higher than the estimated prevalence of true mental disorder. Among those who were screened positive for severe mental

Table G.2

<table>
<thead>
<tr>
<th>Diagnoses</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>60</td>
<td>47</td>
<td>73</td>
<td>49</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>24</td>
<td>10</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>Major affective disorder</td>
<td>56</td>
<td>45</td>
<td>70</td>
<td>42</td>
</tr>
<tr>
<td>Substance abuse/dependence</td>
<td>82</td>
<td>55</td>
<td>87</td>
<td>70</td>
</tr>
<tr>
<td>Alcohol</td>
<td>67</td>
<td>46</td>
<td>83</td>
<td>64</td>
</tr>
<tr>
<td>Drug</td>
<td>54</td>
<td>34</td>
<td>35</td>
<td>27</td>
</tr>
<tr>
<td>Dual (mental and substance)</td>
<td>56</td>
<td>27</td>
<td>73</td>
<td>37</td>
</tr>
</tbody>
</table>
disorder, however, the probability of actually having a severe mental disorder is very high—about 52 percent of those screened positive are expected to have a severe mental disorder.

The characteristics of the severely mentally disordered presented in Tables 3.4 through 3.9 in Sec. III are the characteristics of the entire group of persons screened positive for mental disorder, even though only about half of these individuals are expected to truly have severe mental disorder. In precise terms, then, we have described the characteristics of a group of individuals who have high probability of having severe mental disorder. For the sake of convenience, we have in Sec. III consistently referred to this group as the severely mentally disordered.
Appendix H

CHARACTERISTICS OF THE COUNTIES AND THEIR HMD-FUNDED PROGRAMS

For each of the 58 California counties, this appendix provides the following information:

- Population, ethnic composition, and unemployment rate (Table H.1).
- HMD funds received, total mental health budget, and county population (Table H.2).
- County-estimated number of homeless and unduplicated counts of clients who received HMD-funded services (Table H.3).
- Characteristics of the planned HMD-funded program (Table H.4).

The counties in each table are listed by population size.
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**Sources:** California Department of Finance, Population Estimates of California Cities and Counties, Report 86 E-1; County Supervisors Association of California, California County Fact Book 1987, pp. 29, 30, and 67.

**Notes:** Sutter and Yuba have combined HMD-funded programs, so population data are summed and unemployment data are averaged.
### Table H.2

ANNUAL HMD FUNDING, TOTAL MENTAL HEALTH BUDGET, AND POPULATION SIZE

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**SOURCES:** California Department of Mental Health, from list of funding sources for FY 1986-1987, used to calculate the resource base for FY 1987-1988 HMD allocations; California Department of Finance, Population Estimates of California Cities and Counties, Report 86-1.

**NOTES:** Sutter and Yuba have combined HMD-funded programs, so population and budget data are summed. Alpine and Siskiyou counties elected not to participate in the HMD program.
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**Sources:** County departments of mental health HMD program applications to the California State Department of Mental Health; Quarterly State Department of Mental Health Homeless Survey.

**Notes:** NA means the information was not available. Estimates from the county applications were annualized; if ranges of estimates were given, the midpoint was taken. Sutter and Yuba have a combined HMD-funded program. Alpine and Siskiyou elected not to participate in the HMD program.
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**Table H.4 (continued)**

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<tr>
<th>County</th>
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<th>Short-Term Residence</th>
<th>Med.-Term Residence</th>
<th>Int.-Term Residence</th>
<th>Long-Term Residence</th>
<th>Direct/Contract</th>
<th>HMD/At Risk</th>
<th>Subpop. Involved</th>
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<td>Alpine</td>
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<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

**SOURCE:** County department of mental health applications to the state outlining plans for developing the county HMO-funded programs.

**NOTES:** Sutter and Yuba submitted one application for a combined HMO program. NA means not available. Alpine and Siskiyou elected not to participate in the HMO program.

- **(a)** Homeless service provisions existing before HMO: 0 = none; 1 = food, drop-in only; 2 = shelter (and food).
- **(b)** Not mentioned.
- **(c)** Referral only (i.e., notify other agencies of services); 1 = direct only; 2 = both referral and direct; 3 = none.
- **(d)** Plans for residence of less than a week: 0 = no; 1 = yes.
- **(e)** Plans for residence of up to 1 month: 0 = no; 1 = yes.
- **(f)** Plans for residence of 1 to 3 months: 0 = no; 1 = yes.
- **(g)** Plans for conceivably permanent residence: 0 = no; 1 = yes.
- **(h)** Provision of services: 0 = direct only; 1 = contract only; 2 = direct and contract.
- **(i)** Provision of HMO: 1 = primarily HMO; 2 = primarily at-risk population; 3 = equal emphasis on HMO and at-risk population.
- **(j)** Number of subpopulations considered for targeting services: 0 = no; 1 = yes, at proposal stage; 2 = yes, as part of plan; 3 = yes, both at proposal stage and as part of plan.
Appendix I

CASE STUDIES OF FOUR COUNTIES' HMD PROGRAMS
ALAMEDA COUNTY

COUNTY CONTEXT
Demographic Profile

Alameda County is an urban county, located in the northern portion of the state, with the fourth largest county population. It has three major geographical areas from the perspective of program planning: Oakland, Berkeley, and South County. Median family income is below the state average (see Table I.1) and about halfway between that of Orange and Yolo counties. The 1986 unemployment rate was somewhat below the state average. Other economic indicators suggest that Alameda is fairly typical of the state. Almost 40 percent of its population is black or Hispanic; the proportion of the population that is black is more than double that for the state as a whole.

Department of Mental Health Short-Doyle Budget

The FY 1986-87 budget allocation for the department of mental health in Alameda County was $55,142,557. Like Orange and Yolo counties, Alameda allocated nearly 45 percent of its resources to 24-hour services and about 30 percent to outpatient and outreach services (see Table I.2). However, it allocated proportionately six times more for day services and four times less for continuing care than did Orange County. The allocation reflects in part the difference in emphasis on case management between the two counties. Orange County has a sizable case management program operating in each of the county mental health clinics; Alameda County has case managers at three of the outpatient clinics and has a centralized unit staffed by 8 to 10 FTEs, that provide case management services for 150 clients.

The county's allocation for the specific operation of its HMD program is $988,883, about 2 percent of the county's total mental health budget.
Table 1.1

ALAMEDA COUNTY: SELECTED CHARACTERISTICS

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (1/1/86)</td>
<td>1,208,200</td>
</tr>
<tr>
<td>Three largest cities</td>
<td></td>
</tr>
<tr>
<td>Oakland</td>
<td>354,000</td>
</tr>
<tr>
<td>Fremont</td>
<td>153,500</td>
</tr>
<tr>
<td>Berkeley</td>
<td>107,200</td>
</tr>
<tr>
<td>Racial composition</td>
<td></td>
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<tr>
<td>White</td>
<td>67%</td>
</tr>
<tr>
<td>Black</td>
<td>18%</td>
</tr>
<tr>
<td>Other</td>
<td>15%</td>
</tr>
<tr>
<td>Median age</td>
<td>30.7</td>
</tr>
<tr>
<td>Per capita income</td>
<td>$12,676</td>
</tr>
<tr>
<td>(State average: $11,968)</td>
<td></td>
</tr>
<tr>
<td>Median family income</td>
<td>$18,700</td>
</tr>
<tr>
<td>(State average: $21,537)</td>
<td></td>
</tr>
<tr>
<td>Income below poverty line</td>
<td></td>
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<tr>
<td>Individuals</td>
<td>11.3%</td>
</tr>
<tr>
<td>(State average: 11.4%)</td>
<td></td>
</tr>
<tr>
<td>Under age 18</td>
<td>14.2%</td>
</tr>
<tr>
<td>(State average: 15.2%)</td>
<td></td>
</tr>
<tr>
<td>Families</td>
<td>8.7%</td>
</tr>
<tr>
<td>(State average: 8.7%)</td>
<td></td>
</tr>
<tr>
<td>Unemployment rate (1986)</td>
<td>6.6%</td>
</tr>
<tr>
<td>(State average: 7.2%)</td>
<td></td>
</tr>
<tr>
<td>Medi-Cal recipients</td>
<td>11%</td>
</tr>
<tr>
<td>(State average: 11%)</td>
<td></td>
</tr>
<tr>
<td>SSI recipients</td>
<td>3%</td>
</tr>
<tr>
<td><strong>SOURCES:</strong> County Association of California, California County Fact Book, 1987; U.S. Census, 1980.</td>
<td></td>
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</table>
Table I.2
ALAMEDA COUNTY MENTAL HEALTH BUDGET,
FY 1986-87

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>Percent</th>
</tr>
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<tr>
<td>Administrative</td>
<td>$ 1,918,670</td>
<td>3.5</td>
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<tr>
<td>Outreach services</td>
<td>4,559,202</td>
<td>8.3</td>
</tr>
<tr>
<td>24-hour services</td>
<td>24,019,706</td>
<td>43.6(a)</td>
</tr>
<tr>
<td>Day services</td>
<td>9,996,821</td>
<td>18.1</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>12,042,660</td>
<td>21.8</td>
</tr>
<tr>
<td>Continuing care</td>
<td>2,605,498</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$55,142,557</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**SOURCE:** Alameda County Mental Health Plan, 1987.

(a)Includes state hospital allocation.

Alameda County Homeless Population

The county estimated in its 1986 application for HMD funding that it has more than 8,000 homeless persons, with 3,000 more at risk of homelessness. The county indicated that about 35 percent of its homeless, or about 3,000 individuals who are homeless or at risk of becoming homeless, are also mentally disabled.1 However, officials in the Oakland and Berkeley areas believe that up to 50 percent of their homeless are mentally ill.

The Emergency Services Network (ESN) conducted a survey of the HMD population using shelters in Alameda County in February 1987. During a one-week period, 1640 different individuals sought shelter; this was four times more than the number of beds available. According to ESN, on average, each month about 6,000 individuals are turned away from shelters; 80 percent are denied service because of capacity constraints. Among those receiving shelter, some 260 individuals, or about 16 percent, were mentally disabled.2

1It is not known to which time period, e.g., a day, a month, or year, these figures apply.
Pre-HMD Program Activities

About five years before the HMD program was implemented, the Downtown Merchants Association in Oakland formed a task force to address a number of issues related to redevelopment. Although the group's main focus was to generate revenues and plan for the redevelopment effort, they paid some attention to police, social services, and mental health issues, particularly as they related to the missions in the downtown area. The highest-priority need identified was a "safe place" for the homeless; thus a drop-in center was considered to be an appropriate first step in serving this population.

Beginning in FY 1983-84, the county funded the Berkeley Emergency Shelter, which is operated by Berkeley-Oakland Support Services (then called Berkeley Support Services), through the Short-Doyle program. Funding for the shelter is now provided from the HMD allocation.

In the spring of 1985, Alameda County Mental Health Services prepared an application for federal block grant funding, which was submitted through the State Department of Mental Health. The proposal expressed a specific interest in establishing a nontraditional support-services center in downtown Oakland that would provide a variety of services for the homeless, including outreach, advocacy, and self-help intervention. The county received a block grant of $531,000 over three years, which funded the Oakland Independence Support Center.

Thus, discussions about the services needed to address the problems of the homeless mentally disabled were already under way when the HMD program became law. A series of meetings were held with interested participants to formulate a plan for responding to the new allocation of funds. The major areas of need were identified as:

- Benefits and service advocacy
- Social skills service centers
- Case management
- Shelter and temporary housing
- Administrative coordination
The county's application to the state for HMD funds included allocations for each of these activities.

IMPLEMENTATION OF THE HMD PROGRAM

We begin our description of the HMD program in Alameda County by providing an overview of program services, their interrelationships, and the way in which they have been implemented. We then discuss how the program is organized and managed.

Overview of the HMD Program

The Director of Mental Health for Alameda County indicated that their long-term goal is to place and maintain the HMD in long-term housing arrangements. The HMD-funded programs represent the "middle" piece in the county's overall strategy for serving the HMD. The mechanisms for achieving the long-range goals are not yet fully in place. In 1986, the county had applied for funding through the Robert Wood Johnson Foundation to establish a revolving loan fund, low-cost housing, and a network for facilitating housing placements. Because only the top eight candidates were funded, and Alameda County placed ninth in the competition, money to support long-term housing plans did not become available. The lack of funding has meant little improvement in the availability of long-term housing options for the mentally disabled.

Figure I.1 provides a schematic representation of the Alameda County HMD program. The relationships suggested in this figure reflect our sense that the Alameda HMD program is primarily provider-driven. For the most part, services for the county's homeless mentally disabled are provided by independent private providers, many of whom offer multiple services under a single roof. One program director referred to this approach as "one-stop shopping for the homeless." The providers are located predominately in Berkeley and Oakland, and because they do not conduct outreach activities, they mainly serve the HMD who come to the programs' geographic areas.
Fig. I.1--Schematic overview of services for the HMD in Alameda County
Perhaps the most notable feature characterizing the Alameda program in contrast to the Orange County program is the unidirectional flow of the homeless to these discrete providers. There is very little interaction among providers. Typically, referrals are made for other services provided by the same parent funding organization, as indicated by the dashed lines in Fig. 1.1.

Because the organizational structure in each geographic location is unique, we can best understand the Alameda program by reviewing the services in each area on a provider-by-provider basis.

**Berkeley Services.** The Berkeley service units and their respective functions are outlined below, beginning at the top of the diagram in Fig. 1.1 and working counterclockwise. The services described here represent the continuum of care available to the HMD; not all of the providers listed received HMD funding.

1. **Berkeley-Oakland Support Services (BOSS)** operates the Berkeley Emergency Shelter, the Berkeley Multiservice Center, and the Berkeley Drop-In Center in the city of Berkeley. The emergency shelter has 65 beds and accepts single adults, intact and single-parent families, and the mentally disabled. Length of stay is limited to 60 days. The primary source of referral is from the multiservice center, which provides a range of services including food, clothing, assistance in finding shelter, benefits counseling, a mailbox, a telephone, storage facilities, housing location and moving assistance (first month's rent), and peer counseling. The drop-in center provides a safe place for the homeless to stay during the day. It is operated by an independent client board, but receives its funding through BOSS.

2. **Berkeley Mental Health Clinic** is the local outpatient mental health clinic. It receives some referrals from the Berkeley Multiservice Center. Clients may also self-refer for services. This agency operates a mobile crisis team that responds with the police to calls from the community for assistance with mental health crisis situations. It receives no HMD funding.

3. **The Berkeley Emergency Food Project** coordinates three separate services: serving dinner Monday through Friday (known as the "Quartermail" because dinner costs 25 cents); operating a drop-in center three nights a week; and arranging for churches in the vicinity of the UC-Berkeley campus to open their halls for shelter on a rotating basis, serving 60-80 people a night. The staff rotate across all three programs and
provide informal counseling services as well as operating the programs.

4. **The Center for Independent Living (CIL)** primarily provides housing assistance, although classes in independent living skills, assistance with benefits, and job development services are also available. The agency has conducted some outreach work, particularly in People's Park, but generally relies upon individuals to come in and ask for services.

**Oakland Services.** The providers serving Oakland are listed below, beginning at the top of the diagram in Fig. I.1 and moving clockwise. Again, not all of these providers receive HMD funding.

1. **Although Mental Health Advocates (MHA) is located in Oakland, it serves all of Alameda County.** This agency provides advocacy services for obtaining and maintaining various benefits, particularly SSI. It also provides representation for the mentally ill at hearings related to involuntary hospitalizations, generally at Highland Hospital, the county facility.

2. **Highland Hospital** has two secure psychiatric wards with 40 beds to accommodate those placed on involuntary commitments ($150). It also has a 22-bed criminal justice ward. In December 1987, a mobile crisis outreach team began to operate out of the hospital; it responds to calls received by the police regarding mental health crisis situations and is designed to divert inappropriate referrals to the emergency room.

3. There are three outpatient mental health clinics in Oakland: **West Oakland, East Oakland, and Central Oakland Mental Health Clinics.** These provide a range of outpatient mental health services. East Oakland also has one case manager, who works in conjunction with treatment staff at the clinic. The clinics receive no HMD funding. The West Oakland Clinic is run under contract.

4. **Mission S.A.F.E.** is a 30-bed shelter located in East Oakland. It serves single adults, intact and single-parent families, and the mentally disabled. Stay is limited to 30 days, although arrangements may be made with staff for longer stays. The HMD program funds a variety of counseling services, including assistance with benefits and housing. The county homeless plan calls for Mission S.A.F.E to refer to and receive referrals from East Oakland Mental Health Clinic, but for a variety of reasons this has not yet come to pass.

5. **Berkeley-Oakland Support Services** operates the last three agencies in the diagram in Fig. I.1. Although each agency functions somewhat independently, the services are located on separate floors in a converted hotel in central Oakland. On
the first floor is the Oakland Independence Support Center (OISC), a drop-in center open during the day which provides socialization activities, support services (food, restrooms, shower facilities, etc.), and independent living services, including advocacy, living-skills training, and housing search assistance. This program is funded through a federal block grant. OISC also provides intake services for the Oakland Homeless Project, a shelter with 35 beds for the mentally disabled and four beds for the physically disabled. The shelter is located on the second floor. On the third floor is the Rosa Parks Residence, a transitional residential facility with 12 beds. Most of the residents in Rosa Parks come from the Oakland Homeless Project shelter. The latter two programs receive HMD funding.

South County. A few private shelters operate in this area with about 148 beds, but these shelters are not linked into any of the services associated with the HMD program. From the beginning of the HMD program, county officials were trying to locate a shelter/multiservice center in South County (Hayward/Fremont). The county only recently found and purchased a building in Hayward which is being renovated and will open in the summer of 1988. ROSS will operate a multiservice center, including a 24-hour shelter, out of this facility. Although there were other reasons, the facility hasn’t opened primarily because of the difficulty in obtaining a property.

Allocation of HMD Funds

Table I.3 shows the allocation of HMD funds by agency and services provided. The county has established contracts with six private agencies and the county hospital to provide a range of services for the homeless mentally disabled. Most of the contractors provide more than one type of service.

There have been no major changes since the application was originally submitted to the state. Most of the HMD funds were allocated to drop-in and socialization service activities and shelter-based activities. The remaining third of the budget is allocated for benefits and housing advocacy and crisis outreach through three different providers.
Table I.3

**ALLOCATION OF HMD FUNDING BY CONTRACTOR AND SERVICE, 1987**

<table>
<thead>
<tr>
<th>Contractor</th>
<th>Amount</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berkeley-Oakland Support Services(a)</td>
<td>$396,421</td>
<td>Shelter, drop-in, multiservice center, transitional residential facility</td>
</tr>
<tr>
<td>Berkeley</td>
<td>$9,180</td>
<td>Counselor</td>
</tr>
<tr>
<td>Berkeley Emergency Food Project</td>
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<td>Housing advocacy</td>
</tr>
<tr>
<td>Center for Independent Living</td>
<td>25,500</td>
<td></td>
</tr>
<tr>
<td>Oakland</td>
<td>$81,080</td>
<td>Benefits advocacy</td>
</tr>
<tr>
<td>Mental Health Advocates</td>
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<td></td>
</tr>
<tr>
<td>Highland Hospital</td>
<td>$95,235</td>
<td>Mobile crisis outreach</td>
</tr>
<tr>
<td>Mission S.A.F.E.</td>
<td>76,500</td>
<td>Counseling</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South County shelter(b)</td>
<td>$262,954</td>
<td>Shelter, multiservice center</td>
</tr>
<tr>
<td>Administration</td>
<td>151,889</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$1,098,759</td>
<td></td>
</tr>
</tbody>
</table>

**SOURCE:** Supplemental Data for Specific Fund Sources, MH 1900-C, Fiscal Year 1986-87, Alameda County.
(a) Services within agency include: Berkeley Multiservice Center, Oakland Homeless Project, Rosa Parks Residence, Berkeley Emergency Shelter, Berkeley Drop-in Center, Oakland Independence Support Center.
(b) Not operational.

Three programs have been implemented relatively slowly: South County shelter, Highland Hospital Community Crisis Response Team, and Mission S.A.F.E. The South County shelter is still not operational primarily because of the delay in locating the facility, which is now being renovated. The Highland Hospital program began operating in December 1987; its delay was caused by the variety of county policies that needed to be followed and by the time it took to work out an arrangement with the Oakland Police Department. Mission S.A.F.E. is operating, but continues to experience some difficulties related to finishing the physical plant. Money for that effort from the City of
Oakland and other sources ran out before the project was complete and the program has experienced delays in obtaining additional funding. Some initial delays in other programs were attributed to the need for training staff and for renovation of one facility.

Organization and Management

The Homeless Coordinator for Alameda County reports to the Director of the Office of Management Services, who reports to the County Mental Health Director. The Homeless Coordinator assumed his position in February 1986. Before this the position did not exist, and the current position is considered temporary; the coordinator was required for the various activities needed to start the HMD program and the early stages of coordination. After program implementation is complete, another office within the department of mental health will assume the ongoing management functions necessary to operate the contracts. The coordinator has no county staff who report directly to him. His current responsibilities include program development and monitoring, troubleshooting, and other contract management activities.

The Homeless Coordinator and representatives from all of the contractors meet monthly to discuss issues of mutual interest. The Homeless Coordinator also attends the monthly meeting of BOSS. The Emergency Services Network, which includes a large group of providers operating throughout the county, meets monthly. The contracted programs also interact to some extent with other parts of the mental health system, in particular the outpatient mental health clinics.

Alameda County follows the mandate in the Short-Doyle law to contract out any new activities for which community-based service providers are already able to offer the service. The general belief is that services can be provided less expensively through contract than through county-direct operation. Hence, private providers have received 82 percent of the HMD dollars. The temporary Homeless Coordinator position and the mobile crisis outreach team at Highland Hospital are the only two county functions supported with HMD funds.
Most of the providers now serving the homeless were operating before the HMD program began (see Table I.4), with several having begun operation in the early 1970s. Contracts were awarded on a sole-source basis after discussions with potential providers. For all providers, the availability of new funding represented an opportunity to expand the services they were already providing or to add new services. Three of the programs do not operate their HMD-funded activities separately from the rest of the agency activities; one operates a separate facility; and another now has a full-time staff person whose activities are completely supported with HMD funds. The proportion of HMD funding in each of the agency budgets ranges from 3 to 50 percent. No program is solely funded with HMD funds.

The HMD programs in Alameda County must conform to the reporting requirements for all county contractors. This information is more extensive than that required by the state. During the initial stages of program implementation, the Homeless Coordinator requested monthly reports from contractors, but these have now been replaced by monthly meetings and quarterly reports that are generally narrative in form and descriptive of program activities. One program does have a formal evaluation written into its budget contract, and some attention is being given to replicating this practice with other contractors.

The coordinator monitors contractors, visiting the programs and actively assisting in solving problems as necessary. This may go beyond simple technical assistance. For example, the coordinator has devoted substantial effort to assisting Mission S.A.F.E. with various fiscal and physical plant problems because of the importance of having a shelter facility in East Oakland.

The county is planning some formal training programs for contractors operating under the HMD program. The Homeless Coordinator is developing a series of workshops which will be incorporated into the monthly contractor meetings. The topics identified for these workshops include:
Table I.4
CHARACTERISTICS OF AGENCIES RECEIVING CONTRACTS WITH HMD FUNDS

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>GIL</th>
<th>OISC</th>
<th>BOSS</th>
<th>Mission S.A.F.E.</th>
<th>Mental Health Advocates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual budget</td>
<td>$900,000</td>
<td>$266,500</td>
<td>$1,123,000</td>
<td>$150,000</td>
<td>$250,000</td>
</tr>
<tr>
<td>Percent HMD funds</td>
<td>3</td>
<td>38</td>
<td>33</td>
<td>50</td>
<td>32</td>
</tr>
<tr>
<td>Percent private funds</td>
<td>50</td>
<td>Small local funding</td>
<td>30</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Type of agency</td>
<td>Independent living development and skills, housing, jobs, physical disability (social)</td>
<td>Drop-in social center; support services; independent living (mental health)</td>
<td>One stop shopping center for homeless; various services (social)</td>
<td>Shelter with counseling and case management for residents (social)</td>
<td>Benefits advocacy; info/referral; community education; represent people in 14-day holds (mental health)</td>
</tr>
<tr>
<td>New or expanded</td>
<td>Added full-time housing search counselor; also part-time benefits counselor</td>
<td>HMD funds used for building renovation and rent</td>
<td>Added case management and direct shelter services; Oakland facility expanded</td>
<td>Added counseling services for residents; added 10 beds</td>
<td>No new services; Ensure advocacy to meet demand; assist at-risk population; outreach to OISC 2 days/week</td>
</tr>
<tr>
<td>Not addition?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Operated separately?</td>
<td>Counselor is separate; work in same building</td>
<td>No</td>
<td>Yes; Oakland facility is HMD only; Berkeley shelter is addition</td>
<td>No</td>
<td>Yes, except for outreach to OISC</td>
</tr>
</tbody>
</table>

SOURCE: Telephone interviews with Program directors.
• Violence and aggressive clients
• Assessment of clients
• The dual diagnosis client
• AIDS information and prevention
• Housing--Sec. VIII and other low-cost options
• Public assistance: legal, medical, AFDC, SSI
• Stress reduction
• Behavioral issues--schizophrenics and counseling
• Saying no to clients; setting limits

Most program directors have a baccalaureate or master's degree; most also have significant work experience in social service or mental health agencies. A few have had personal experiences with homelessness or mental disability.

PERSONS SERVED

Having provided an overview of the HMD program, we now focus on its individual components. Below we discuss overall program activities and describe the clients served.

Overall Program Activities

Table I.5 shows the number of unduplicated clients and units of services provided during one-week periods in December 1986, March 1987, and June 1987. The number of clients served doubled between December 1986 and March 1987, mostly due to a doubling in the number of meals served, and a large increase in use of both money management services and shelter beds. The number of clients seems to have stabilized between March and June. Fewer beds were being used, but the number of shelter nights more than doubled between March and June. Although the average number of meals served has declined back to December levels, the food category increased dramatically suggesting a similar level of activity in this subsistence area.
Table I.5

ALAMEDA COUNTY OVERALL HMD PROGRAM ACTIVITIES

<table>
<thead>
<tr>
<th>Activity</th>
<th>December 1986</th>
<th>March 1987</th>
<th>June 1987</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unduplicated clients</td>
<td>405</td>
<td>974</td>
<td>970</td>
</tr>
<tr>
<td>Average # beds used</td>
<td>89</td>
<td>276</td>
<td>130</td>
</tr>
<tr>
<td>Average # meals served</td>
<td>329</td>
<td>700</td>
<td>351</td>
</tr>
<tr>
<td>Assessments</td>
<td>73</td>
<td>129</td>
<td>139</td>
</tr>
<tr>
<td>Referrals</td>
<td>49</td>
<td>451</td>
<td>253</td>
</tr>
<tr>
<td>Shelter</td>
<td>300</td>
<td>323</td>
<td>848</td>
</tr>
<tr>
<td>Food</td>
<td>581</td>
<td>436</td>
<td>970</td>
</tr>
<tr>
<td>Clothing</td>
<td>95</td>
<td>111</td>
<td>61</td>
</tr>
<tr>
<td>Financial support</td>
<td>--</td>
<td>48</td>
<td>21</td>
</tr>
<tr>
<td>Money management</td>
<td>5</td>
<td>105</td>
<td>88</td>
</tr>
<tr>
<td>Psychotropic medication</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Mental health day services</td>
<td>110</td>
<td>192</td>
<td>195</td>
</tr>
<tr>
<td>Mental health outpatient</td>
<td>--</td>
<td>25</td>
<td>10</td>
</tr>
<tr>
<td>Mental health 24-hour care</td>
<td>--</td>
<td>2</td>
<td>--</td>
</tr>
<tr>
<td>Case management</td>
<td>106</td>
<td>161</td>
<td>93</td>
</tr>
<tr>
<td>Involuntary hospitalization</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Transportation</td>
<td>24</td>
<td>73</td>
<td>107</td>
</tr>
<tr>
<td>Board and care placement</td>
<td>--</td>
<td>10</td>
<td>--</td>
</tr>
</tbody>
</table>

SOURCE: County reports to the State Department of Mental Health.

NOTE: Figures represent the cumulative level of activities over a one-week period during the month indicated.

Client Characteristics

Table I.6 summarizes the characteristics of clients served by the HMD program. The characteristics differ somewhat among the various service providers; however, in general, the services focus on the homeless rather than on those at risk of becoming homeless. There was a belief often expressed during our site visit that "anyone who was homeless was at risk of becoming mentally disabled"; thus many of the programs make no particular effort to screen for mental disability. Still program directors estimate that a majority of their clients are mentally disabled (50-100 percent), and of those, program directors believe that 25 to 50 percent are severely mentally disabled. Many
appear to suffer both from substance abuse disorders and mental
disability. It was clear from discussions with program staff that the
dual diagnosis population represents a major concern in this county.

The majority of clients were described as minority and below the
age of 40. In most programs, women were estimated to represent from 40
to 60 percent of the clients.

Only one program, the Center for Independent Living, focuses on a
special population group. The CIL was originally established to serve
the physically disabled; however, prior to the HMD program
implementation it had expanded its mission to include services to the
mentally disabled.

Table I.6

CHARACTERISTICS OF PERSONS SERVED BY HMD-FUNDED PROGRAMS

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>BOSS</th>
<th>MHA</th>
<th>Mission S.A.F.E.</th>
<th>CIL</th>
<th>OISC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>avg. 31</td>
<td>22-35</td>
<td>25-65</td>
<td>20-60</td>
<td>30-50</td>
</tr>
<tr>
<td>Age</td>
<td>60</td>
<td>60</td>
<td>90</td>
<td>63</td>
<td>80</td>
</tr>
<tr>
<td>Percent minority</td>
<td>60</td>
<td>50</td>
<td>75</td>
<td>40</td>
<td>65</td>
</tr>
<tr>
<td>Percent male</td>
<td>60</td>
<td>40</td>
<td>100</td>
<td>100</td>
<td>80</td>
</tr>
<tr>
<td>Percent homeless</td>
<td>65</td>
<td>100</td>
<td>50</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Percent mentally disabled</td>
<td>50</td>
<td>90</td>
<td>25</td>
<td>DNK</td>
<td>DNK</td>
</tr>
<tr>
<td>Percent severely mentally disabled</td>
<td>20</td>
<td>5</td>
<td>75</td>
<td>50%+</td>
<td>50%</td>
</tr>
<tr>
<td>Special population groups</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Physically disabled</td>
<td>None</td>
</tr>
</tbody>
</table>

SOURCE: Telephone interviews with program directors.
NOTE: DNK means Do Not Know.
PROGRAM ACTIVITIES

We now turn to a description of individual program activities. Rather than grouping this discussion by provider, we focus on some of the types of program activities that were of particular interest to the legislature and the Department of Mental Health.

Outreach

The county department of mental health has given each contractor the option of providing outreach services for bringing clients into each program. Only one agency, the Center for Independent Living, does limited "on-the-street" outreach. It has one person who does street-based outreach about once a week sometime between 9 a.m. and 5 p.m., the hours when the agency is open. An estimated six new contacts a week are made. No services are actually offered on the street. The prospective client is handed a flyer that describes the services offered by CIL. Individuals who wish to take advantage of the services must come to the CIL offices near the Berkeley campus. The outreach worker continues to work with clients who come in for as long as they are willing to visit the center, providing services on both a drop-in and appointment basis.

Mental Health Advocates performs a different type of outreach by outstationing one worker two days a week at the Oakland Independence Support Center. The MHA worker has regularly scheduled hours (Tuesdays and Wednesdays from 1 p.m. to 3 p.m.), and anyone interested in obtaining benefit assistance (SSI, General Relief, food stamps) can receive services during those times. Appointments are occasionally made for people to come into the MHA offices for additional help. About 15-20 clients are seen on each of the scheduled days at OISC. According to the counselor who provides the outreach services, there are no differences between the clients seen while at OISC and those who come

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3Initially, this person spent more time on outreach, but he reported that increased awareness of the program among the potential client population has decreased the need for the frequency of this activity.
into the MHA offices; but many of the individuals met at OISC will not come to the MHA offices and thus might not otherwise obtain services. Upon request of a program director, MHA will also send a representative to the Berkeley Drop-In Center or to any of the shelters in Alameda County.

The Homeless Coordinator indicated that the absence of active outreach programs designed to link clients directly into the county mental health system reflects a perception that the county services are already operating beyond their capacity. He suggested that it did not make sense to increase the number of new clients at a time when existing clients cannot be adequately served.

Intake and Screening

All of the agencies receiving HMD funds conduct their own intake activities (see Table 1.7). Each has its own intake form, although the BOSS agencies use the same form. Intake activities at MHA, CIL, and BOSS are intended to identify the services that the client wants and/or needs and to determine the resources available to meet those needs. Intake activities at OISC are directed at screening for mental illness, which is based primarily on the history of treatment for mental disorders. Because OISC does intake screening for the Oakland Homeless Project which has stricter entry criteria, the screening at OISC is perhaps the most stringent of all agencies. The screening for entry to OISC is more restrictive now than it was initially because capacity constraints forced the program to become more selective.

Three of the agencies we visited, OISC, BOSS, and Mission S.A.F.E., say they operate at capacity and regularly turn away clients.

Case Management

Each HMD program is responsible for conducting its own case management activities. In most of the programs, case management consists of working with the client to identify needed services and suggest strategies for obtaining those services. Continuity of services generally requires that the client continue to show up at the provider.
### Table I.7
CHARACTERISTICS OF INTAKE ACTIVITIES

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>MHA</th>
<th>CIL</th>
<th>OISC</th>
<th>BOSS</th>
<th>Mission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conducts intake activities?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Written screening protocol?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Screen for:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homelessness</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>At risk of homelessness</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mental status</td>
<td>No</td>
<td>Yes</td>
<td>Yes(a)</td>
<td>No(b)</td>
<td>Yes</td>
</tr>
<tr>
<td>Use DSM-III</td>
<td>--</td>
<td>No</td>
<td>No</td>
<td>--</td>
<td>No</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Determine eligibility for:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entitlements</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Services</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Clients turned away each day</td>
<td>Rare</td>
<td>None</td>
<td>~2/day</td>
<td>10%</td>
<td>10/day</td>
</tr>
<tr>
<td>Reasons</td>
<td>Acting out; impaired</td>
<td>Operating at capacity; violent; not eligible</td>
<td>Operating at capacity; violent; will not follow rules</td>
<td>Operating at capacity; violent; will not follow rules</td>
<td></td>
</tr>
<tr>
<td>Who screens for mental status?</td>
<td>N/A</td>
<td>Counselor</td>
<td>Counselor</td>
<td>N/A</td>
<td>Social worker</td>
</tr>
</tbody>
</table>

**SOURCE:** Telephone interviews with program directors.

**NOTE:** N/A means not applicable.

(a) Information obtained about history of illness and treatment.

(b) Ask whether individual is receiving benefits; assume that receipt of SSI indicates presence of mental disability.
The use of written plans is uneven and is dependent on the service provided. Rarely are family or friends involved in service planning, although most program directors suggested that this was due to individuals having no contact with family members rather than an unwillingness on the part of the agency to engage family members in the service delivery process. Reportedly, cases remain open with an agency up to six months, but generally the duration of service delivery is shorter.

Case management services through county mental health are provided in three of the outpatient clinics and through a central specialized services unit. This activity does not receive HMD funding.

One indicator of the effectiveness of case management activities is the referral flows into and out of the various agencies. We had difficulty obtaining adequate information on these flows and thus base our comments on the self-reports of program directors. BOSS is the only agency that reported making regular referrals for mental health services to the county mental health clinics. Only OISC and MHA report receiving referrals from county mental health clinics. About 50 percent of MHA's referrals come from county mental health, and this is largely through the contract with the county to provide representation for clients at involuntary hospitalization hearings. Most of the HMD service agencies reported that 50 percent or more of their clients are self-referrals. The balance are referrals to them by other agencies. Few referrals were reportedly made through outreach activities.

There was a mixture of opinion regarding the ability of programs to maintain the HMD in service on a long-term basis. A senior official of the county department of mental health believes that most of the HMD are not currently engaged in a continuum of services and that they are on the periphery of the county mental health service delivery system naturally gravitating toward subsistence services. Others believe that the agencies are fairly successful in maintaining clients within their respective service delivery system and that the funding through the HMD program is particularly helpful in ensuring their service continuity. Staff at Mental Health Advocates believe that the agency is effective in
maintaining benefits for people over a longer period than would otherwise be possible. The first year is particularly critical for long-term maintenance of SSI benefits because there are multiple reviews in the first year; after that, there are fewer challenges to eligibility. Staff at another agency believe that limited resources (both financial and nonfinancial) affect that agency's ability to maintain clients on a long-term basis because of the unavailability of low-cost housing and jobs at skill levels appropriate for their clientele.

Drop-In Centers

Four "drop-in" centers have received some form of funding from the HMD program. Two of them, the Oakland Independence Support Center and the Berkeley Drop-In Center, offer a place for clients to stay during the day, as well as obtain services. Only one, the Berkeley Emergency Food Project, operates in the evenings.

The Berkeley Drop-In Center is a client-run organization that offers a broad range of services, including peer counseling, living skills, referrals, and basic convenience services such as bathrooms, laundry, and a mailbox. However, it does not serve a daily meal. One Sunday a month the center provides a dinner. The center accommodates about 60 clients a day, two-thirds of whom are "regular" clients. The center is open for drop-in on Tuesdays and Thursdays from 10:00 a.m. to 5:00 p.m., Wednesdays from 9:00 a.m. to 1:00 p.m., and three Saturdays a month from 1:00 p.m. to 5:00 p.m. In addition to the drop-in hours, there are special activities on other days, such as a women's group that meets on Monday evenings and videos two Friday evenings a month. The center is currently located in an old school building, sharing the space with several other unrelated programs. There are plans to move to a new, dedicated location as soon as appropriate conditional use permits are obtained.

The Oakland Independence Support Center is a client-run organization that offers food and the same general range of convenience services as the Berkeley Drop-In Center. It serves about 83 persons a day, about half of whom are regular clients. According to a report made by OISC to the Mental Health Advisory Board, in an average month about
16 percent of clients use information and referral services, 29 percent receive shelter referrals, 14 percent use advocacy services, 20 percent participate in living skills training, 14 percent use housing search assistance, and 22 percent take advantage of the peer counseling program. It is open every day except Thursday, operating from 9:30 a.m. to 5:30 p.m. during the week and from 12:00 noon to 4:00 p.m. on the weekend. It is located on the first floor of a converted hotel; HMD funds were used for the renovation. OISC is staffed with 9 full- or part-time employees and also contracts with clients to provide various volunteer services.

The third drop-in center, the Berkeley Multiservice Center, is a somewhat different type of center in that it offers no socialization activities and no space to "hang out." However, it does provide a mailbox, representative payee program, benefits counseling, and clothing to about 120 clients a day, two-thirds of whom are estimated to be regulars. The ongoing caseload is about 1,000 although most of those are only receiving mailbox services. About 200 individuals receive their SSI check at the multiservice center. The center is open Monday through Friday from 9:00 a.m. to 4:00 p.m., except on Tuesday when it closes at 2:00 p.m.

The Berkeley Emergency Food Project operates three nights a week (Monday, Tuesday, and Thursday) from 7:00 p.m. to 9:30 p.m. in a church hall. Staff indicated that they are hoping to open one additional night a week beginning in January of 1988. The drop-in center offers a safe place for people to stay during the evening. There are five staff available for counseling and socialization activities; a small snack and coffee are also provided. About 50-70 clients use the drop-in center each night.

Financial Assistance
The only financial assistance program funded by the HMD program in Alameda County is the one at the Berkeley Multiservice Center. This is not an unduplicated count. The county operates a subpayee program through the central specialized services unit. OISC has a money management program.
offers both a representative payee and a money management program. There are 35 clients in the representative payee program and another 15-25 in the money management program. The program helps clients establish a budget, with particular emphasis on providing adequate funds for rent and food, and then assists clients in living within the budget. For some clients this means receiving a small amount of money each day for discretionary spending. More typically, clients get spending money once a week. The program establishes a schedule for receiving funds, which is fairly inflexible in order to manage the flow of cash and to maintain discipline. According to staff, these programs are fairly time consuming to operate, and thus the multiservice center has a limited capacity for providing them. There is a greater need in Alameda County for representative payees. Reportedly, the county had approached Mental Health Advocates about serving as a representative payee for clients, but was turned down because the program was not in keeping with MHA’s main mission.

Mobile Crisis

The Highland Hospital Community Crisis Response Team had not begun operation when we visited in October of 1987, but began operating in December 1987. The purpose of the program is to provide assistance to police in Oakland who are responding to calls for possible involuntary hospitalizations; the program goal is to increase the proportion of appropriate referrals to Highland Hospital for involuntary hospitalization. In a recent 18-month period, 9,000 cases (7,000 individuals) were brought to Highland Hospital on 5150s for evaluation and treatment, but only 15-20 percent were actually hospitalized.

The program will use a van operating out of the hospital and be staffed by two psychiatric social workers. The program hours will be 3:30 p.m. to 11:00 p.m. and the team will respond to calls phoned into the Oakland police. The time was selected because it is the period during which the police receive the largest volume of calls. The van will carry food and clothing to allow for some basic needs intervention on the spot. Other crisis intervention will be conducted, especially referrals to shelters. Those that appear appropriate for 5150s will be
transported to Highland Hospital. A county official indicated that the program was operating successfully during the first few months and that the county was considering expanding the geographic area covered.

Shelters

Currently 17 shelters for the homeless operate in Alameda County. Their characteristics are provided in Table I.8. In 1986, the shelters provided 413 beds—265 in North County (174 of which are in Oakland) and 148 in South County. This represents an increase of 82 beds over 1985. There are 130 beds available in shelters that serve the mentally disabled, or about 30 percent of the total; these are accessible to other populations as well so the full capacity is not available. The South County shelter, when completed, will have 24 beds for the mentally disabled.

In 1985, 1986, and 1987, the Emergency Services Network conducted surveys of shelter voucher programs and participating agencies. The purpose of the survey was to provide a profile of the homeless population and make an unduplicated count of individuals seeking shelter. About half of shelter residents are single women with children, a third are single men and women, and the remainder are intact families or men with children. Most shelter residents are under 40 (92 percent) and about 40 percent are children under age 12. The proportion of mentally disabled residents has about doubled from 7 percent in 1985 to 16 percent in 1987. Most shelter residents (84 percent) had been homeless for less than six months; 46 percent had been unemployed for more than six months. Almost 40 percent cited the lack of affordable housing as a major obstacle to moving into permanent housing. Other reasons included a variety of income-related issues including waiting time for public assistance.

County Mental Health

We only had the opportunity to interview and visit one of the mental health clinics in the county in any depth. We provide the following description as an illustration of county mental health operations in Oakland, recognizing that other clinics, particularly those in Berkeley, may have different experiences.
Table I.8
SHELTERS IN ALAMEDA COUNTY, 1987

<table>
<thead>
<tr>
<th>Name and Location</th>
<th>Eligible Population</th>
<th>Beds</th>
<th>Length of Stay</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berkeley</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Berkeley Emergency Shelter(a)</td>
<td>SM, SW, IF, SPF, MD</td>
<td>65</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Chabad House</td>
<td>JM</td>
<td>10</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Oakland</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salvation Army</td>
<td>IF, SPF</td>
<td>40</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>The Women's Refuge</td>
<td>W&amp;C</td>
<td>19</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Peniel Mission</td>
<td>SM</td>
<td>30</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>A Safe Place</td>
<td>BW&amp;C</td>
<td>20</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Mission S.A.F.E.(a)</td>
<td>IF, SPF, SM, SW, MD</td>
<td>30</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Oakland Homeless Project(a)</td>
<td>MD</td>
<td>35</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Alameda</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Filipinos of Alameda</td>
<td>IF, W&amp;C</td>
<td>16</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>South County and Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Outreach Agency</td>
<td>SM</td>
<td>16</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Emergency Shelter Program</td>
<td>W&amp;C</td>
<td>40</td>
<td></td>
<td>7-30</td>
</tr>
<tr>
<td>Shelter Against Violent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environments</td>
<td>BW&amp;C</td>
<td>25</td>
<td></td>
<td>30-90</td>
</tr>
<tr>
<td>Second Chance</td>
<td>IF, SPF, SM, SW</td>
<td>15</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Shepherd's Gate</td>
<td>W&amp;C</td>
<td>16</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>Tri-Valley Haven for Women</td>
<td>BW&amp;C</td>
<td>16</td>
<td></td>
<td>30-45</td>
</tr>
<tr>
<td>Family Crisis Center for Families</td>
<td>IF, SPF</td>
<td>14</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Family Crisis Center for Men</td>
<td>SM</td>
<td>6</td>
<td></td>
<td>60</td>
</tr>
</tbody>
</table>

SOURCE: Emergency Services Network.
NOTE: SM=single men, IF=intact families, MD=mentally disabled, SW=single women, SPF=single parent families, JM=jewish men, W&C=women and children, BW&C=battered women and children.
(a)Shelters receiving HMD funds.

The East Oakland Mental Health Clinic is an outpatient clinic providing therapy, day treatment, socialization, and children, youth, and family services. The average monthly caseload is about 1,000.
There are 32 full-time equivalents (FTEs) providing direct services.
The catchment area has a population of 200,000 which is considered by many to have some of the worst drug abuse, unemployment, infant mortality, and school drop-out rates in the nation. Almost 70 percent of the population in the catchment area is black or Hispanic. The director indicated that the clinic serves the most severely disturbed. Most patients have schizophrenia or major affective disorder. About 70 percent of clients are black and 5-7 percent are Hispanic. About 66 percent are on Medi-Cal.

The clinic director indicated that the homeless in East Oakland are different from other homeless in that they have not chosen the lifestyle. Most have been living somewhere else—typically with a family member or church member or in a board and care home—and for some reason cannot remain in the living situation. About 20 percent of the clinic's clients are currently homeless. As a rule, county mental health does not get involved in making housing placements because there is no reimbursement for that activity.

The clinic is operating at capacity most of the time. Anyone walking in will receive an intake assessment. Clients are triaged, with those in the most critical conditions receiving service that day. If there is no waiting list, an appointment can be made in three or four days. If there is a waiting list, it can "take months" to get a follow-up appointment.

The East Oakland Mental Health Clinic was concerned about clients who were "falling between the cracks" and instituted a case manager to deal with such clients. The case manager meets with clinicians regularly to discuss the social needs of their ongoing clients. The bulk of work has been in housing placements. The case manager rotates from team to team and generally carries a caseload of about 6 clients. She may have 30-40 other referrals active at any one time in other stages of assistance.
Residential Treatment and Housing

Two major programs funded through the HMO allocation provide services directly related to placement in residential treatment and housing: Center for Independent Living and the Rosa Parks Residence. Although other programs indicate that they provide assistance in referring clients to housing, most were unable to give us specific information about the rate of successful placements. The county specialized services unit provides placement services under Short-Doyle for clients being treated in the county mental health system.

The Center for Independent Living has a counselor that provides assistance to clients seeking permanent independent living arrangements. The program relies primarily on client self-referral and will serve anyone who indicates that they have a mental or emotional problem. No formal assessment is conducted. Clients are seen on a first-come, first-served basis, and no waiting lists are maintained (everyone is seen). Clients typically come looking for assistance with housing, jobs, and income. The counselor makes an initial determination of what the client needs and then helps the client work on a strategy for meeting those needs. The "self-help" orientation of the program means that clients must be motivated to help themselves—they must do the footwork based on the counselor's suggestions and recommendations.

During the first quarter of FY 1987-88 (July through September of 1987), CIL had 101 clients; 207 were served in FY 1986-87. Among the clients seen, 23 found permanent living arrangements (about 23 percent); 12 found their housing through the CIL counseling and housing lists. About 57 percent were male; among the women, 42 percent were heads of households. Of the 68 clients served in June, 41 were from Berkeley, 26 from Oakland, and the remainder from the rest of Alameda County.

The Rosa Parks Residence is located on the third floor of a converted hotel in downtown Oakland. There are 12 beds in the residence, which is intended to provide a transition to independent living within six months. Most referrals come from the Oakland Homeless Project shelter located on the second floor of the same building. The residence serves both men and women. Clients (called "guests" by the
program) are matched with a counselor who is responsible for providing an individualized plan of action. This plan is formalized in a written contract, which is reviewed weekly. Terms of the contract depend on the needs and situation of the individual. The residence provides breakfast seven days a week and dinner Monday through Thursday. A kitchen is available for preparation of meals at other times. Rent is charged depending on the client's income; generally, rent is one-third of the client income or $150, whichever is greater.

The program was operating below capacity when we visited for a variety of reasons including staff transitions and construction of the kitchen. There were 6 residents, 4 on general assistance and 2 on SSI. Four were in the 18-35 age range and the other 2 were between 36 and 59. One individual had been there 15-28 days; one for 45-60 days; 3 for 60-120 days; and one for 120-180 days. Only one new intake was conducted in September of 1987. Staffing transitions are over and the kitchen is complete, so the census is expected to increase again. Also, Federal Emergency Management Agency (FEMA) money for housing assistance was spent, which encouraged more shelter clients to consider the residence as an alternative. Although no figures were available, the impression we received was that most clients moved from Rosa Parks into a permanent housing situation.

EFFECTS OF THE HMD PROGRAM

We now discuss the effects of the HMD program on coordination of services, and consider the extent to which the HMD in Alameda County were targeted, engaged, and provided services on a long-term basis. We also discuss the effects the program has had on the community as seen through the eyes of our respondents.

Coordination

The provider-based nature of the Alameda County program seems to result in little active effort to coordinate the delivery of services. Many of the agencies provide the same set of services to potentially the same set of clients. We are not making a judgment about whether this approach is more effective than a centrally controlled and operated
system, rather we observe that coordination of services is not a major focus of the Alameda system.

Interaction among providers has increased some due to the monthly contractor meetings conducted by the Homeless Coordinator. These offer contractors the opportunity to share the progress and experiences of their programs, and presumably others benefit from the dialogue. Program directors and county officials indicated to us that these meetings had contributed to greater awareness among providers of the other services offered in the community.

Another source of service coordination is the monthly meetings of the Emergency Services Network (ESN). This forum brings together a broader group of providers than the contractor meetings. ESN has several committees that are responsible for considering a variety of issues and recommending approaches for the county to take. Much of the information collected by ESN in its annual shelter survey has been used by the county to plan and set priorities for expenditures on services to the homeless.

Targeting and Engaging the HMD

The first issue is to identify the population that is being targeted to receive services. The self-help orientation found in Alameda County is in part reflected in the lack of active outreach programs. We found an attitude in many programs that those who really wanted help would come looking for it. Those are in fact the clients on whom most programs focus. Because most programs do not conduct detailed intake, particularly with respect to assessments of mental status, there is little screening out of clients. We would guess that these factors combine to result in services being targeted on higher functioning individuals than those who are gravely disabled under the 5150 legal definition. We would guess that those with disorders including paranoia that make them suspicious of seeking assistance from anyone would not receive services.

However, staff members in most of the agencies believe that they are concentrating their attention on those with severe mental illness, and there is a general perception that because HMD funds have gone
largely to client-run groups, some pre-existing barriers to service have been reduced. For example, the Berkeley Drop-In Center has no formal ties to the Berkeley Mental Health Clinic, and clients provide support for those eschewing traditional mental health services. Program staff believe that this provides an environment that is conducive to attracting the more severely mentally ill.

Most agency directors felt that they could not adequately serve the dual diagnosis population. Further, they indicated that the problem is extensive; estimates ranged from a low of 5 percent to a high of 75 percent of clients with dual diagnosis problems. The perception of most staff we spoke with during the site visit was that the majority of homeless clients had drug and/or alcohol abuse problems as well. Two reasons were given by staff for the extent of the problem. First, drugs and alcohol provide a "coping" mechanism for people living on the streets. Second, for those with mental disabilities who are not on medication, drugs and alcohol may represent an effort to self-medicate to reduce symptoms.

Individuals engaged in substance abuse tend to be screened out of the programs, either directly because of program policy or because they present behavior problems. We were told that most mental health agencies will not admit someone for treatment who is currently abusing substances, and most drug and alcohol programs are reluctant to treat those with mental disorders. Staff indicated that approaches to treatment for the substance abuse and mental disability populations are quite different and in conflict with one another. Although efforts are under way to coordinate services with the Drug and Alcohol Services agency, no programs are currently in place to address the special needs of this population.

Serving the HMD

Four dimensions of the services provided to the HMD merit special attention: subsistence, entitlements, mental health services, and long-term housing placements.
Subsistence. One of the innovations of the HMD legislation was allowing mental health agencies to fund the delivery of subsistence services, including shelter, food, clothing, and other services necessary to meet basic life needs. From conversations with legislative staff, we infer that this was based on a belief that these services were necessary to engage the HMD into the system.

Alameda County is funding up to 130 shelter beds through the HMD program, and some of the agencies with which it contracts provide other subsistence services. The quarterly survey conducted by the state is perhaps the most comprehensive indicator of the extent to which these services are provided by HMD-funded contractors. As shown in Table I.5, the number of clients provided with subsistence services is substantially larger than the number receiving other types of services. This is dominated by the number of meals served (presumably by shelters), shelter days, and clothing. Interestingly, while the average number of beds used tripled, the shelter nights remained roughly the same. Whether this is an artifact of the data or has another explanation is unclear given the lack of instructions on how to complete the state form.

One of the questions that should be addressed in future research is whether the presence of subsistence services does in fact encourage individuals to enter a system they might not otherwise enter. It would be necessary to follow clients longitudinally to determine what represents a "typical" path for a new client to the system; that is, clients may progress from subsistence services to income stream services (entitlements or jobs) to mental health services, or different types of clients may use each type of service.

Entitlements. A key step in moving from homelessness to a more stable living situation is securing a stream of income. For many this means obtaining access to entitlements such as Supplemental Security Income. One of the contract agencies, Mental Health Advocates, has as a primary mission assisting clients in obtaining and maintaining benefits. All other private contractors provide varying levels of help to clients in obtaining benefits. During FY 1986-87, Mental Health Advocates
served 926 individuals through its HMD contract. In the first quarter of 1987-88, the agency had provided services to 173 individuals through the homeless contract. The agency opens about 30 to 40 new cases each month and closes about the same number. The "units of service" provided each month run about 230 to 250, and cases tend to be open anywhere from one month to one year. We were not able to obtain data on the proportion of individuals who actually obtain benefits, so it is difficult to assess the success rate of obtaining entitlements. The policy of the agency is to work with clients as long as the client is willing.

Mental Health Services. The HMD who are not already in the county mental health system may or may not be linked up with or receiving mental health services from the county mental health system; we do not have enough data to assess this. Our belief is that such assistance is the exception rather than the rule, for several reasons. First, most of the private contractors indicate that they do not have strong referral ties to county mental health. Thus, anyone who is not already in the system is unlikely to be referred there by the private contractors. Second, numerous officials indicated that the Alameda County mental health system is operating at capacity and that waiting times for appointments can be as long as several months. This contributes to a further reluctance to refer individuals to a system which may not be able to accommodate them. Third, there is a strong self-help group influence in Alameda County which has been antagonistic to the traditional mental health system. These groups are well represented among the private contractors who received HMD funds. While county officials indicated that relations between county mental health and the self-help groups had improved, the attitudes are consistent with our observation of few linkages between HMD-funded programs and county mental health. Many of these programs provide peer support and peer counseling as alternatives to more traditional mental health treatment. To date a small proportion of clients who benefit from the HMD program, however, appear to have been referred to and eventually served by the county department of mental health service delivery system.
Long-Term Housing Placements. One of the goals in the legislation was to ensure that individuals were eventually moved into long-term housing. In general, few data are available on the number of individuals who have been placed in permanent housing as a result of contact with an HMD provider. The March 1987 report to the state reported that ten placements had been made in board and care homes over a one-week period. The Center for Independent Living estimates that 23 of 101 clients were placed during the first quarter of FY 1987-88; 12 of the 23 had found their housing through the listings of the agency.

Many program staff and directors that we spoke with indicated that there was a need for more affordable housing for the homeless, particularly the mentally disabled. Shelters made these individuals a low priority before HMD funding was available, and in the same way, in a "seller's" market the mentally disabled are likely to have relatively more problems competing for scarce housing.

Effects on Community

Some believe that the HMD program, along with the Emergency Services Network, has increased community awareness about the problems of the homeless and the homeless mentally disabled. Emergency Services Network provides a forum for discussing the issues related to serving this population, and the media have provided coverage on the homeless and homeless mentally disabled. However, others believe that little, or at least not enough, has been done to educate the public.

Despite the mixed assessment of community awareness, county mental health officials agree that the HMD program has had a positive effect on the approach taken by mental health providers toward the HMD population. They believe that basic social services play an important role in enhancing mental health, and that there is something to be gained by the more traditional approaches, which are not required to undertake some type of therapeutic intervention. Issues surrounding service to the HMD have been discussed at some length with the mental health clinic directors. One issue of particular concern is the waiting time for clinical appointments, which ranges from 3 to 5 weeks in one clinic and up to 8 months in another.
The HMD program seems to have had only a limited effect on the social services agencies. One respondent noted that most of the activity in the social services existed before the HMD program, although activity has increased some. For example, SSI staff have assisted at some of the forums held for the homeless and have conducted several training classes in the outpatient clinics, and Mental Health Advocates has increased the number of clients it assists in completing forms.

The County Board of Supervisors is aware of the HMD program and has been supportive. They oversee a county-wide task force on homelessness and expect the county department of mental health to provide leadership on the homeless issue. The police, as well as a variety of other agencies, are represented on this task force.

Several agencies have made specific efforts to sensitize the policy to the problems that the HMD face. The Berkeley Mental Health Clinic mobile crisis team now works closely with the police and conducts joint training sessions. The recently organized Mobile Crisis Outreach Program at Highland Hospital is also involving the police in training and is ready to respond with them to calls from the community. Other agencies, such as OISC, have also worked with the police.

PROPOSED CHANGES AND PRIORITIES

Generally, agency respondents indicated that they could use additional HMD funds for expansion of current services. There was some convergence of views about how to allocate such an "increase." An increase to the county would be used to complete the continuum of services as was intended to be done with the Robert Wood Johnson grant. The primary focus would be on providing long-term housing and the financial support for people to move into housing. Transitional housing would be necessary to break the cycle of people rotating through shelters. The second priority would be case management.

Beyond this, individual respondents favored establishing a substance abuse program or increasing job referral and job training development activities.
A senior official of the county department of mental health believes that more funds are necessary, but expressed concern that categorical funding such as that provided by the HMD program could displace some of the severely disabled population currently being served in county clinics. If the HMD program was successful at placing more HMD in the mental health system, the result might be a lower level of service to the most severely ill. Currently, 70 percent of the population seen in the outpatient clinics have been diagnosed as schizophrenic or having a major affective disorder. Because the system is currently operating at capacity, other less severely disabled persons are turned away.

Another respondent believes that more attention should be given to case management and outreach services and that the other services, such as counseling and basic needs, should be provided on the streets. In addition, there is a need for more beds at all levels and a need for long-term, low-cost housing and for housing search assistance.

GAPS IN SERVICES

Below we discuss the remaining and possible gaps in services available to the HMD. Opinions from county officials, program directors, and staff are combined with our own observations.

Dual Diagnosis

Every respondent agreed that the dual diagnosis clients remain one of the major underserved groups among the HMD. These clients present a particular challenge to both mental health and substance abuse agencies because their traditional approaches may not be appropriate for these clients. Efforts are under way to develop some joint programs between the two agencies but clear models do not appear to be available for implementation. There is a perception among program staff that Alameda County has one of the most serious problems in the state with dual diagnosis clients.
Transitional and Supported Housing

Most respondents pointed to the lack of both transitional and permanent housing options as a major gap in delivering services to the HMH. This gap was recognized by the county in its application to the Robert Wood Johnson Foundation for funding. The indication from staff was that the problem is likely to become more serious as more Sec. VIII housing certificates expire, further decreasing the availability of low-cost housing arrangements.

Another gap is the availability of semisupervised or supported housing arrangements. These represent an alternative to the traditional board and care system, which offers a very structured living environment and may be unacceptable to many individuals.

Outreach Services

There is very little active, on-the-street outreach being conducted in Alameda County for reasons discussed above. This probably affects the type of clients who are receiving services currently. Although the perception remains that outreach makes little sense in a system that is operating at capacity, some program staff suggested that there was a need for outreach services.

Follow-up Services

Few agencies conduct much follow-up activity, which in part explains the difficulty in obtaining numbers about client outcomes. Most program staff and directors indicated that they would do more follow-up if additional resources were available. The director of mental health suggested that the lack of follow-up may be a contributing factor to "recycling" individuals back into homelessness. One county official mentioned a study that had been done suggesting that a six-month follow-up period was necessary to prevent individuals from returning to homelessness.
Medical Care

The director of mental health and program staff at one of the shelters mentioned medical care as an outstanding service gap. Medical care is difficult, if not impossible, to access for individuals not facing life-threatening health conditions. One of the health clinics in Alameda County has started a mobile health van that visits some of the shelters on a regular basis to provide some basic health services.

Crisis Services

The director of mental health indicated that there was a need for 24-hour crisis management services. The mobile outreach van programs in Berkeley and Oakland serve this need to some extent, but they only operate during limited hours.

Physically Disabled

One respondent singled out the physically disabled as being particularly disadvantaged in obtaining shelter services. They tend to be excluded from most programs, in many cases simply because facilities cannot accommodate them.
COUNTY CONTEXT

Demographic Profile

Orange County, the third largest county in California, is predominantly urban. It is one of the most affluent counties in the state, as shown in both income indicators and the proportion of the population on Medi-Cal and SSI (see Table I.9). Its minority population (22 percent) is predominantly Hispanic and it has the second largest proportion of Southeast Asian refugees in the state.

Department of Mental Health

The FY 1986-87 budget allocation for the county department of mental health was $50,704,623. Nearly half is allocated to 24-hour services and about one-third to outpatient and outreach services (see Table I.10). Continuing care services represent the county's case management effort, which is substantially larger than that in Alameda County.

The county's allocation for the operation of its HMD program is $1,113,019--including local share--about 2 percent of the county's total mental health budget; it is to be used for the benefit of "those chronically mentally ill persons who are living under circumstances which do not meet their health, safety, or other daily needs."

County Homeless Population

County estimates of its homeless population contained in its 1986 application for HMD funding range broadly from 2,200 to 30,000 persons\(^1\) included in the following four categories:

\(^1\)It is not known to which time period, e.g., a day, a month, or year, this range applies.
Table I.9

ORANGE COUNTY: SELECTED CHARACTERISTICS

<table>
<thead>
<tr>
<th>Population (1/1/86)</th>
<th>2,145,700</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three largest cities</td>
<td></td>
</tr>
<tr>
<td>Anaheim</td>
<td>237,500</td>
</tr>
<tr>
<td>Santa Ana</td>
<td>225,800</td>
</tr>
<tr>
<td>Orange</td>
<td>101,600</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Racial composition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>78%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>15%</td>
</tr>
<tr>
<td>Black</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>6%</td>
</tr>
</tbody>
</table>

| Median age | 29.5 |

<table>
<thead>
<tr>
<th>Per capita income</th>
<th>$13,027</th>
</tr>
</thead>
<tbody>
<tr>
<td>(State average: $11,968)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Median family income</th>
<th>$25,918</th>
</tr>
</thead>
<tbody>
<tr>
<td>(State average: $21,537)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income below poverty line</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals</td>
<td>7%</td>
</tr>
<tr>
<td>(State average: 11.4%)</td>
<td></td>
</tr>
<tr>
<td>Under age 18</td>
<td>9%</td>
</tr>
<tr>
<td>(State average: 15.2%)</td>
<td></td>
</tr>
<tr>
<td>Families</td>
<td>5%</td>
</tr>
<tr>
<td>(State average: 8.7%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Unemployment rate (1986)</th>
<th>4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(State average: 6.2%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medi-Cal recipients</th>
<th>4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(State average: 11%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SSI recipients</th>
<th>1.4%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(State average: 2.9%)</td>
<td></td>
</tr>
</tbody>
</table>

SOURCES: County Association of California, California County Fact Book, 1987; U.S. Census, 1980.
Table 1.10
ORANGE COUNTY MENTAL HEALTH BUDGET

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$2,538,363</td>
<td>5</td>
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<tr>
<td>Outreach services</td>
<td>4,830,522</td>
<td>9</td>
</tr>
<tr>
<td>24-hour services</td>
<td>22,554,423</td>
<td>45</td>
</tr>
<tr>
<td>Day services</td>
<td>1,516,992</td>
<td>3</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>11,021,692</td>
<td>22</td>
</tr>
<tr>
<td>Continuing care</td>
<td>8,242,642</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$50,704,623</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**SOURCE:** Orange County Mental Health Plan, 1987.

- Socially marginal (at risk)
- Situationally homeless
- Episodically homeless
- Chronically homeless

Based on estimates from the American Psychiatric Association that 25 to 50 percent of the homeless are mentally disabled, the county then estimated that from 550 to 15,000 of its homeless population are mentally ill. Within this range, the coordinator of the HMD program in Orange County estimated that there are 5,000 HMD in the county. The HMD program has an estimated capacity to serve about 1,000 HMD annually.

**Pre-HMD Program Activities**

Before the implementation of the HMD program, the most critical areas of underservice to the HMD reported by county officials were:

- Shelter
- Food, clothing, and other basic needs
- Long-term residential facilities
- Income maintenance

Before receiving the HMD allocation, the county mental health system had no specific programs targeting on the HMD. The homeless mentally ill were served, if at all, under the general umbrella of the county mental health system, although some were singled out through crisis intervention (primarily through the 5150 process). The county mental health Continuing Care Unit did refer homeless individuals to both treatment and board and care placements, but no reliable estimates of the number of these referrals are available.\(^2\)

The private sector was, and is, also providing some services for the homeless in general, but nothing specifically for the mentally ill. Until recently, St. Mary's Episcopal Church in Laguna Beach provided sanctuary for the homeless within the church; SOS in Costa Mesa (an organizational element of Orange County Interfaith Services) provided meals and other services; and the Episcopal Services Alliance ran a shelter for homeless women in the San Clemente area. None of these privately run services could provide a precise estimate of their expenditures directly involved in support of the homeless or the HMD.

**IMPLEMENTATION OF THE HMD PROGRAM**

We begin our description of the HMD program in Orange County by providing an overview of program services, their interrelationships, and the way in which they have been implemented. We then discuss how the program is organized and managed.

\(^2\)Reportedly, one staff member of the Continuing Care Unit in the Santa Ana Clinic used to spend 20 percent of the work time dealing with homeless persons. All homeless persons are now referred initially to the HMD outreach team.
Overview of Orange County's HMD Program

The intent of the Orange County program for the homeless mentally disabled has been to develop a comprehensive system of services that will supplement rather than supplant existing programs in the county's continuum of mental health care. According to county officials, the main objectives of the program are to:

- Identify the HMD and provide case management assistance
- Provide basic subsistence services
- Provide mental health services
- Reduce the number of HMD living on the streets
- Place HMD in long-term housing
- Educate the community about the problems of the HMD

The county's strategy for meeting the goals of its HMD program has focused on three areas: outreach/case management, shelters, and drop-in centers² (see Table I.11 for funding allocations). The purpose of

Table I.11
BUDGET FOR HMD PROGRAM, FY 1986-87

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach/</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case management</td>
<td>$408,067</td>
<td>37</td>
</tr>
<tr>
<td>Drop-in centers</td>
<td>353,900</td>
<td>32</td>
</tr>
<tr>
<td>Shelters</td>
<td>261,535</td>
<td>23</td>
</tr>
<tr>
<td>Administrative</td>
<td>89,517</td>
<td>8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,113,019</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

SOURCE: Orange County FY 1986-87
Short-Doyle plan.
NOTE: Total includes local share.

²The county department of mental health operates a jail diversion program using other funds.
the outreach/case management program is to coordinate services for the HMD, with an emphasis on establishing positive relationships with clients, particularly those mistrustful of the traditional mental health delivery system. The program is also designed to encourage use of, and facilitate access to, shelter programs and drop-in centers.

Figure I.2 provides a schematic representation of the Orange County HMD program. The relationships in this figure are not meant to suggest, nor are they an abstraction of, a formal chart prepared by the county to represent the intentions of the HMD program. Rather, the figure reflects our sense of how the various units interact.

The county outreach team is the central component of the HMD program, working in close cooperation with the drop-in center in Santa Ana. Staff on the team have two primary responsibilities: outreach (engaging the HMD either directly or through referrals) and case management (assisting the HMD on a case-by-case basis to acquire needed and wanted services).

Initial contacts made by the outreach team with potential clients are intended to ascertain eligibility for the program (individual is homeless and mentally disabled) and to determine whether the individual is interested in receiving services. Outreach workers make an informal assessment of eligibility through conversations with clients about their current living situation, history of treatment for mental illness, and ability to provide for their own welfare. As shown in Figure I.2 (starting at the top and continuing clockwise), contacts with clients come either directly through street outreach or from referrals from county mental health, benefits programs, other service providers, community members, the police, shelter operators, and the drop-in center. Although active outreach is an important part of the Orange County HMD program, about two-thirds of the outreach team's client contacts come from referrals from other sources including benefit agencies, other service providers, and county mental health.

Figure I.2 also shows the referral flows from the outreach team to other services. These include the drop-in center, shelters, county mental health, benefits agencies, and other service providers.
Fig. 1.2--Schematic overview of services for the HMD in Orange County
The primary strength of the Orange County organizational structure is its flexibility, which allows for a customized delivery of services depending upon what the client needs and wants. However, its effectiveness also depends upon the resourcefulness and dedication of the outreach workers, the degree of cooperation and support from entitlement agency workers and service providers, and the geographic proximity of the outreach workers to these providers. Because the tasks of engaging and transporting the HMD and managing their service applications are time consuming, each member of the outreach team carries a fairly small caseload (5-10) at any one time.

The one currently operating drop-in center provides food, clothing, restrooms, laundry and shower facilities, transportation, pre-vocational services, community resources information, an on-site peer counselor, a mailbox, and games and other socialization activities. It is also a focal point for linking clients to shelters and other services. The drop-in center serves 50 to 80 persons a day.

In addition, the HMD program contracts with seven shelters with a capacity of up to 124 beds; only 30 to 40 beds are available at any one time. These shelters are open to other homeless individuals, but give priority to those with HMD program vouchers.

In the first year of the HMD program, the county rolled over about $800,000 of its funding, and in FY 1986-87, about $272,000. The outreach program became operational almost immediately, and the availability of contract shelter beds has grown during the time the program has been in operation.

The greatest implementation difficulty has been with the drop-in centers. Community opposition and the resulting difficulties in obtaining appropriate conditional use permits have delayed opening the centers. The contract was awarded to the provider, the Mental Health Association of Orange County, in July of 1986, and the process of obtaining permits and approvals was begun in two different locations—Santa Ana and South County. However, local residents believed that the programs for the homeless would bring large concentrations of homeless individuals into their communities and brought pressure to disapprove
both potential sites. One center opened at a temporary location in January 1987, and moved to its permanent home at the Santa Ana YMCA in November 1987, where a new use permit was not needed. The second facility is scheduled to open in early 1988 at another South County site.

Organization and Management

Direct responsibility for coordinating the county's HMD funded programs lies with the Supervisor of Adult Homeless Outreach Services. The supervisor is an employee of the county department of mental health, and his wide-ranging responsibilities include supervising the operations of the outreach unit; monitoring shelter bed contracts; overseeing outreach, shelter, and drop-in center activities; delivering community presentations; interacting with the Mental Health Advisory Board; and indirectly supervising quality of care assessment in the shelters. He reports to the Manager of Adult Aftercare Services, a position two levels down from the Director of Mental Health.

Services for the homeless in Orange County are provided both directly by the county (45 percent of funds) and through contracts with various providers (55 percent of funds). Members of the outreach/case management team are county employees. Shelter services, on the other hand, are operated by contract providers; and while the outreach team provides vouchers to be used by the HMD in these approved contract shelters, the beds in the shelters are "set aside" rather than restricted for use by the HMD program. The drop-in centers are also operated under contract, the provider in this case being the Mental Health Association (MHA) of Orange County, a private organization founded in 1958 before the county had a mental health department.

Contracted services were awarded through a competitive process. The county contracted out the shelter services because it did not want to become directly involved in the "housing" business. In contracting out the drop-in centers, however, the county was consciously endeavoring to involve community groups in planning and providing services for the HMD.
The county conducts a quarterly evaluation of its programs, including site visits, to determine the quality of services rendered, whether adequate space is provided, whether the facilities meet cleanliness standards, and whether activities are conducted as contracted. Renewals of contracts are based on a nonviolation of contract terms. The MHA must also provide a report on contract expenditures.

Although there are no ongoing formal training programs for those working with the HMD, two countywide in-service training programs have focused on identifying the homeless mentally ill, including techniques for interviewing and engaging them. The Homeless Coordinator believes that additional training is needed for community agencies providing services. The most acceptable type of training from the perspective of these agencies is on techniques or methods to improve program functioning. Two topics mentioned were recognition of mental illness and program intake procedures.

PERSONS SERVED

We now turn to a description of overall program activities and the clients they serve. Below we present greater detail on the services previously described.

Overall Program Activities

Table 1.12 shows the number of unduplicated clients and units of services provided during one-week periods in December 1986, March 1987, and June 1987. The increase in mental health day services between December and March is attributable to the opening of the drop-in center in January. Since that time, the drop-in center activity appears to have leveled off. The most significant increase was in the assessments category. As we would expect, given the structure of the program, most of the services are focused on subsistence and day services with little activity in treatment and placement.
Table I.12

ORANGE COUNTY OVERALL HMD PROGRAM ACTIVITIES

<table>
<thead>
<tr>
<th>Activity</th>
<th>December 1986</th>
<th>March 1987</th>
<th>June 1987</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unduplicated clients</td>
<td>45</td>
<td>220</td>
<td>162</td>
</tr>
<tr>
<td>Average # beds used</td>
<td>18</td>
<td>29</td>
<td>31</td>
</tr>
<tr>
<td>Average # meals served</td>
<td>45</td>
<td>128</td>
<td>164</td>
</tr>
<tr>
<td>Assessments</td>
<td>32</td>
<td>128</td>
<td>622</td>
</tr>
<tr>
<td>Referrals</td>
<td>31</td>
<td>81</td>
<td>28</td>
</tr>
<tr>
<td>Shelter</td>
<td>144</td>
<td>30</td>
<td>59</td>
</tr>
<tr>
<td>Food</td>
<td>339</td>
<td>612</td>
<td>162</td>
</tr>
<tr>
<td>Clothing</td>
<td>1</td>
<td>21</td>
<td>26</td>
</tr>
<tr>
<td>Financial support</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Money management</td>
<td>1</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Psychotropic medication</td>
<td>4</td>
<td>--</td>
<td>7</td>
</tr>
<tr>
<td>Mental health day services(a)</td>
<td>--</td>
<td>324</td>
<td>162</td>
</tr>
<tr>
<td>Mental health outpatient</td>
<td>10</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Mental health 24-hour care</td>
<td>1</td>
<td>--</td>
<td>59</td>
</tr>
<tr>
<td>Case management</td>
<td>--</td>
<td>137</td>
<td>--</td>
</tr>
<tr>
<td>Involuntary hospitalization</td>
<td>1</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Transportation</td>
<td>45</td>
<td>342</td>
<td>162</td>
</tr>
<tr>
<td>Board and care placement</td>
<td>1</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

SOURCE: County report to the State Department of Mental Health.

NOTE: Figures represent the cumulative level of activities over a one-week period during the month indicated.

(a) Represents the drop-in center.

Client Characteristics

Table I.13 displays the demographic characteristics of mentally ill homeless which were engaged and had a case open during the February through March 1986 time period. At that time, most were male, white, below the age of 40, and single. Nearly half had schizophrenia, 15 percent had affective disorders, and 15 percent had substance abuse disorders (see Table I.14). The drop-in center estimates that

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Tabulations of the characteristics of clients served are not made routinely. This is the latest period for which such data were available to us.
Table I.13
DEMOGRAPHICS OF MENTALLY ILL
HOMELESS CASES OPENED BY
OUTREACH TEAMS,
FEBRUARY 21-MARCH 31, 1986

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>50</td>
<td>75</td>
</tr>
<tr>
<td>Female</td>
<td>17</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>67</td>
<td>100</td>
</tr>
<tr>
<td><strong>Race/ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>57</td>
<td>85</td>
</tr>
<tr>
<td>Black</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>67</td>
<td>100</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-29</td>
<td>31</td>
<td>46</td>
</tr>
<tr>
<td>30-39</td>
<td>23</td>
<td>34</td>
</tr>
<tr>
<td>40-49</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>50-59</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>60 years &amp; over</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>67</td>
<td>100</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Separated</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Never married</td>
<td>42</td>
<td>63</td>
</tr>
<tr>
<td>Divorced</td>
<td>18</td>
<td>27</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>67</td>
<td>100</td>
</tr>
<tr>
<td><strong>Veteran</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>No</td>
<td>61</td>
<td>91</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>67</td>
<td>100</td>
</tr>
</tbody>
</table>

**SOURCE:** Orange County Department of Mental Health, outreach services program statistics.
Table I.14
DIAGNOSTIC CATEGORY FOR HOMELESS MENTALLY ILL,
FEBRUARY 21-MARCH 31, 1986

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>30</td>
<td>45</td>
</tr>
<tr>
<td>Affective disorder</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Organic disorder</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Developmental disability</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Substance abuse disorder</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Others (adjustment disorder,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sexual disorder, personality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>disorder)</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>100</td>
</tr>
</tbody>
</table>

SOURCE: Orange County Department of Mental Health, outreach services program statistics.

approximately 98 percent of its clients are homeless. The outreach team serves both the homeless and those at risk of becoming homeless, but about 85 percent of clients are currently homeless. Both the outreach and drop-in center programs serve only the mentally disabled, and most of the individuals seen are considered by program directors to be severely mentally ill.

PROGRAM ACTIVITIES
Below we describe the Orange County HMD program activities in more detail.

Outreach/Case Management
The Adult Homeless Outreach Services unit within county mental health has two primary responsibilities: outreach and case management. The purpose of the outreach function is to contact and engage individuals who are not being served and to determine the appropriate set of services for each person. The purpose of case management is to follow up on clients contacted through the outreach program (either on
the street or from referral sources), ensuring that the needed services are being obtained. Staff members carry an average caseload of 5 to 15 clients at any given time.  

**Outreach** has three major components:

Active on-the-street outreach aimed at engaging individuals who appear homeless and mentally disabled. This includes approaching people in food lines, parks, bus stations, the Santa Ana riverbed, and other places where the homeless are likely to congregate. All staff members carry beepers, which allows the central administrative offices to contact them when they are in the field.

Outreach in response to referrals. Referrals constitute the majority of the activity conducted by the team, accounting for about 60-70 percent of the team’s client contacts (about 10-20 individuals per week). The team receives referrals from a wide range of sources, including SSI, General Relief, board and care operators, hospital emergency rooms or inpatient facilities, jails, the drop-in center, and other agencies both county and private. The workers also maintain close ties with the continuing care units in county mental health clinics.

Outreach designed to educate the community and private agencies about the availability of services for the HMD and techniques for dealing with these individuals. This educational component has had a direct bearing on both the number and appropriateness of referrals received by the team since the implementation of the HMD program.

Case management includes identifying the set of services the client is willing to accept and then assisting the client in obtaining those services. This may include making appointments at mental health clinics or benefits agencies, filling out applications, transporting the client to appointments, writing vouchers for shelters, and providing bus tokens for transportation to appointments.

The outreach/case management team consists of five full-time and two part-time employees, providing direct services, and two clerks. Four members of the team have mental health training and/or experience; two have backgrounds in social work; the team generally has a student or other "volunteer" worker as well. Two team members are Spanish speaking, which allows the team to more effectively serve this relatively large minority group within the county. (There is also a minority group coordinator for all mental health services.)

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*Orange County set a target of 15-20 clients per outreach staff member. By comparison, case managers in the county department of mental health: Continuing Care Unit carry a caseload in the 50-60 range.*
The program operates from 8 a.m. to 5 p.m. on weekdays, although someone is on call to respond to emergencies during evening and weekend hours.

Table I.15 shows the sources of referrals to the outreach team. Nearly one out of four were referred by the Continuing Care Unit or Adult Outpatient Services of county mental health, and most of the balance were referred from the community, including other service providers, benefit agencies, and county residents. One out of ten of those referred had previously been in the program. Nearly all (92 percent) of the 422 individuals referred over a five-month period were provided temporary housing in shelters.

In addition to its usual activities, the outreach team has undertaken a number of special projects:

* When the St. Mary's Episcopal Church shelter program in Laguna Beach was in operation, an outreach worker consulted with the staff and clients and conducted intake and assessments.

* Staff members sponsor a group session once a week at one of the contract shelters, discussing issues of consequence to the HMD (such as eligibility for SSI) and providing group level assistance for common problems.

Table I.15

REFERRALS TO OUTREACH TEAM,
JULY-NOVEMBER 1987

<table>
<thead>
<tr>
<th>Source</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>County mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing Care Unit</td>
<td>84</td>
<td>20</td>
</tr>
<tr>
<td>Adult Outpatient Services</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Jail</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Community</td>
<td>318</td>
<td>75</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>422</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

SOURCE: Orange County Department of Mental Health, personal communication.
In a pilot program, a worker was outstationed for a month in the Santa Ana General Relief office, during which time he contacted 346 clients, 13 percent of whom were found to be mentally disabled. Prior to the pilot program, the homeless team had received only eight referrals from this GR office in a six to nine month period. Funds were inadequate to extend the program beyond the pilot phase.

SSI has participated in two-way training with the team and an SSI eligibility worker picks up completed applications from the outreach office once a week, relieving clients of the burden of having to apply in person. This has reportedly reduced the number of disturbances experienced by SSI in its offices from the HMD.

After a tuberculosis outbreak in one of the shelters, a public health nurse provided training for the team on reading TB tests and recognizing other diseases. Public health officials were having difficulty in getting clients back on the day the TB tests needed to be read, and so the outreach team read tests as they saw clients throughout the county.

The factors that the team considers most significant in a successful outreach effort include repetitive contact with clients and agencies; developing a rapport with individuals; educating staff in other agencies; providing an opportunity for outreach staff to vent their frustrations; flexible scheduling; and strong clinical skills, which are of more immediate importance than diagnostic skills.

Intake and Screening

The county has developed a definition of the chronically mentally ill homeless that it uses as entry criteria to the HMD program. The criteria emphasize limitations in functioning (e.g., inability to provide for subsistence needs, lack of direction or motivation, limited ability to work, symptoms like hallucinations); the criteria also include those who are living in conditions that do not meet basic needs (see field definition in App. A).

The outreach worker generally asks a series of questions about treatment history, length of homelessness, work history, and benefits. While the outreach staff do not make clinical diagnoses, they screen for the presence of chronic mental illnesses such as schizophrenia and major
affective disorder. If permission can be obtained to review the client's medical records, the worker also verifies the client's history of treatment and hospitalizations. Additionally, the worker tries to link individuals to county mental health for a more complete mental health exam. Finally, the outreach worker performs a needs assessment and develops a written service plan. (App. B contains the guidelines for the needs assessment and service plan, the Intake form, and the Mental Status Examination form.)

All of the current outreach workers have some inpatient hospital experience with the mentally ill, and the coordinator has emphasized enhancing skills related to recognizing the mentally ill and attempting to engage them in the system.

The program does not shelter anyone who is intoxicated or high. These individuals are referred to Drug and Alcohol Services for detoxification and counseling. The program will work with dual diagnosed clients if they agree to "stay clean" while in the program.

Drop-In Centers

The drop-in center has a variety of functions, all of which are important to the overall success of the program. First, most of the shelter programs require an individual to be away from the premises during the day, and the drop-in center provides a safe place for these individuals to stay. Transportation is provided daily between the contract shelters and the center. Second, the drop-in center is accessible to anyone wanting to spend time there. Some individuals continue to use the center after they have been placed in permanent housing. Others who will not use any other services in the program will still visit the drop-in center. Third, the outreach workers use the drop-in center as a place to meet clients and bring clients encountered during the day. Fourth, the center provides a number of basic subsistence services, as well as socialization skill activities, to assist individuals in making the transition from a homeless situation to permanent housing.
As noted earlier in the discussion of program implementation, only one of the two planned drop-in centers is operating. The second is scheduled to open in early 1988. The drop-in center is open 7 days a week from 8 a.m. to 5 p.m., and has three staff available on-site during most of the hours of operation. Between 50 and 80 individuals visit the center each day, and the program serves up to 900 meals a week. About 90 percent of the clients are regular users of the drop-in center.

Financial Assistance

No money management or representative payee programs operate in Orange County that are designed to serve the HMD. This is discussed below in the subsection "Gaps in Service."

Shelters

Seven shelters with a total capacity of up to 124 beds are funded under contract by the HMD program (see Table I.16). Over half of this capacity is located in Santa Ana (68 beds), with the balance distributed among the City of Orange (36 beds), Garden Grove (8 beds), and Westminster (12 beds).

With two exceptions, each shelter specializes in one specific subpopulation, e.g., families, men, women only. One shelter, with six beds, is accessible to the physically disabled. To access the shelters and receive priority, the HMD are given vouchers by the outreach team. In total, 72 beds can be set aside for the HMD, but only about 30 are available at any one time. The average length of stay in a shelter is about six weeks.

In addition, there are 16 shelters, not HMD-funded, with a total capacity exceeding 470 beds located throughout the county. Most of them serve families or battered women and children.
Table I.16
SHELTER FACILITIES IN ORANGE COUNTY

<table>
<thead>
<tr>
<th>Name by Location</th>
<th>Population Served (a)</th>
<th>No. of Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaheim</td>
<td>BW&amp;C</td>
<td>10</td>
</tr>
<tr>
<td>Eli Home</td>
<td>RM</td>
<td>NA</td>
</tr>
<tr>
<td>Costa Mesa</td>
<td>SM,SW,F&amp;C</td>
<td>70-75</td>
</tr>
<tr>
<td>Orange Coast Interfaith Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Garden Grove</td>
<td>PD,MD</td>
<td>8</td>
</tr>
<tr>
<td>Dayle McIntosh Center (b)</td>
<td>BW&amp;C</td>
<td>12-18</td>
</tr>
<tr>
<td>The Sheepfold</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fullerton</td>
<td>F&amp;C</td>
<td>20</td>
</tr>
<tr>
<td>New Vista</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irvine</td>
<td>F&amp;C</td>
<td>25</td>
</tr>
<tr>
<td>Irvine Temporary Housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laguna Beach</td>
<td>BW</td>
<td>18</td>
</tr>
<tr>
<td>Human Options</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orange</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christian Temporary Housing</td>
<td>F&amp;C</td>
<td>40</td>
</tr>
<tr>
<td>Martha House (b)</td>
<td>SW</td>
<td>10</td>
</tr>
<tr>
<td>Jerry McGee’s Place (b)</td>
<td>SM,SW</td>
<td>22</td>
</tr>
<tr>
<td>Leisure Towers IV (b)</td>
<td>SM</td>
<td>4</td>
</tr>
<tr>
<td>San Clemente</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anchor House</td>
<td>F</td>
<td>14</td>
</tr>
<tr>
<td>Santa Ana</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDC-Safety Net</td>
<td>BW&amp;C</td>
<td>20-25</td>
</tr>
<tr>
<td>Hospitality House</td>
<td>SM,SW,F&amp;C</td>
<td>50</td>
</tr>
<tr>
<td>Missionaries of Charity</td>
<td>F&amp;C</td>
<td>NA</td>
</tr>
<tr>
<td>Orange County Rescue Mission</td>
<td>SM</td>
<td>85</td>
</tr>
<tr>
<td>YMCA (b)</td>
<td>SM</td>
<td>30</td>
</tr>
<tr>
<td>YWCA (b)</td>
<td>SW</td>
<td>38</td>
</tr>
<tr>
<td>Tustin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Hope</td>
<td>F&amp;C</td>
<td>48</td>
</tr>
<tr>
<td>The Sheepfold</td>
<td>BW</td>
<td>10-12</td>
</tr>
<tr>
<td>Westminster</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelter for the Homeless (b)</td>
<td>SM,F</td>
<td>12</td>
</tr>
</tbody>
</table>


(a) Abbreviations stand for: SW = single women; SM = single men; F&C = families with children; BW = battered women; BW&C = battered women and children; RM = religious members; F = families; PD = physically disabled; MD = mentally disabled; NA = not available.

(b) NMD contract shelters.
County Mental Health

The Adult Homeless Outreach Services unit, which has the outreach/case management function, is located within the Adult Aftercare program in the Orange County Department of Mental Health. This is the same program that contains the Continuing Care Unit, which provides case management services for clients with chronic mental disorders. The organizational proximity of these functions has resulted in fairly close coordination between the HMD program and subsequent services delivered by the Continuing Care Unit, although the relationship differs somewhat across the various county clinics.

The outreach/case management services represent the largest single program in the budget, thus the county is actively involved in service delivery to this population. Further, while the shelters are operated under contract, the outreach team controls access through the voucher process and is responsible for monitoring the quality of services delivered in the shelters.

According to the Homeless Coordinator, one of the county clinics that sees the largest number of HMD clients has made considerable efforts to adjust operations to meet the needs of this population. Perhaps one of the most dramatic examples of this flexibility is a client who is on SSI and chooses to live on the Santa Ana riverbed. Both the Homeless Unit and the Continuing Care Unit have tried working with him to find a more suitable living arrangement, but he has steadfastly refused such opportunities. He has, however, provided his case manager with a map of the riverbed, indicating the three areas where he is most likely to spend time. If he has not been in for an appointment for about two weeks, the case manager will go looking for him. The case manager has also worked with him to plan some trips out of the area so that his budget will last. He has made several trips within a budget successfully since they began this process.

The Continuing Care Unit estimates that about 5-10 percent of its caseload are HMD clients, although many more would be considered at risk of becoming homeless.
The Adult Treatment Services Unit has a team that is also responsible for conducting 5150 evaluations during the weekday business hours (the police are responsible for issuing 5150s during other times). This was the traditional route into the mental health system in the past. During the months of July through September of 1987, the unit conducted a total of 310 evaluations resulting in 61 involuntary hospitalizations (51 percent). The Santa Ana clinic service chief for outpatient services indicated that the HMD program had increased the number of 5150 evaluations in the prior six months by 25-30 percent. The Continuing Care Unit may also conduct 5150 evaluations. During the July to September 1987 period, they conducted 86 evaluations, 61 of which resulted in hospitalizations.

The Adult Treatment Services Unit is also responsible for more traditional mental health care delivery in the outpatient setting. Its primary relationship to the HMD program is in providing diagnostic assessments of clients who are new to the Orange County mental health system and in supervising the medication regimens of clients as required. The caseloads carried by this unit are somewhat lower (average 38 per FTE) reflecting the amount of time spent with each patient on average. About 95 percent of continuing care clients are also seen by the Adult Treatment Service Unit; these clients represent about one-third of the clients in this unit.

Residential Treatment and Housing

The county does not fund any residential treatment or housing programs, except shelters, from the HMD allocation. The need for transitional residential and other housing options is discussed in the subsection "Gaps in Services." Placements into long-term housing are discussed below.
EFFECTS OF THE HMD PROGRAM

We now turn to the effects of the HMD program on selected outcomes, including service coordination, targeting and engaging the HMD, the range of services provided, and the effects on the community.

Coordination

Both the Homeless Coordinator and the Director of Mental Health agree that service coordination has increased since implementation of the HMD legislation. Indeed, one of the major functions of the HMD program is to link clients to services. A vital element of this linkage is the fact that outreach workers have county vehicles with which to provide transportation to their clients. The transportation reduces the chances that a client will miss an appointment due to forgetfulness or inability to cope with the mass transit system. The outreach team has also worked to develop close relationships with mental health clinics, benefit offices, police, drop-in center staff, shelter operators, private programs, and others. By establishing an extensive referral network throughout the community, they have greatly extended their effective area of coverage. For example, one very successful experiment was to station an outreach worker in a General Relief office to identify individuals in need of mental health care and to help these individuals process their forms. The county would like to extend this practice to other agencies (SSI, Unemployment, Food Stamps, etc.) that are likely to come in contact with the HMD or other mentally disabled individuals, but to date funding for this purpose has not been available.

The outreach team works fairly closely with county mental health workers, particularly in the early stages of moving someone from the HMD program to the continuing care program in mental health. However, the members of the outreach team have quite a bit more operational flexibility and freedom than their counterparts in the more traditional clinic system. The outreach staff have fewer forms to complete and are not limited by Medi-Cal criteria in the types of services provided, nor are they required to develop a clinical chart containing a full diagnostic evaluation and treatment plan on a client. This flexibility
enables the outreach team to respond more immediately to individual needs in obtaining necessary services, that is, they do not have to begin by conducting a mental health diagnostic work-up before extending services such as shelter.

Targeting and Engaging the HMD

Although it appears that the Orange County program has been largely successful in identifying and engaging the most severely mentally ill homeless, its ability to serve the population does depend on voluntary cooperation by the client, which reportedly can be difficult. Refusals come in part from some of the characteristics or symptoms of mental illness—bizarre comprehension and reactions, delusions, and paranoia. Many individuals have a general distrust of anything associated with a bureaucracy, and a considerable number who have had previous negative contacts with the mental health system are apprehensive of any further encounters. There is also a resistance to taking medications, in part because of the side effects. Since many HMD lack knowledge about available services and how the system works, the outreach team must spend a great amount of time in advocacy on their behalf. The relatively small case load carried by the outreach team members suggests that they are working with more difficult and/or complex cases.

Although voluntary cooperation by the client does sometimes present problems, program directors and staff members are cautious about the desirability of increasing the number of involuntary commitments. Extending conservatorships might be preferable if funding became available to do so.

According to outreach staff, the ability to maintain clients in the system on a long-term basis depends to some extent on what precipitated their homelessness. For many individuals the process has traditionally been to cycle between being homeless and having a home, and for these people the process may always be cyclical. Success may also depend upon the length of time a client has been homeless before the outreach team makes contact with the individual. The longer the period of homelessness, the lower the likelihood the outreach team will be able to make a change in the individual’s living pattern. However, the outreach
program reportedly has thus far experienced only limited client recurrence (about 10 percent).

Serving the HMD

Four dimensions of the services provided to the HMD merit special attention: subsistence, entitlements, mental health services, and long-term housing placements.

Subsistence. In general, for the HMD who are willing to accept services, adequate food and shelter resources appear to be available in Orange County. Food is provided by churches and other groups; the drop-in center serves breakfast and lunch; and the shelters serve dinner. Public officials and private program staff believe that food, clothing, and shelter services are in adequate supply.

The outreach workers control vouchers that allow the HMD access to shelter beds. For those not covered by vouchers, the shelters generally charge a sliding scale fee based on resources available to the individual. Thus far, the shelters and the outreach team have not had to turn away any of the homeless mentally disabled, however, outreach workers may have to place individuals in shelters other than those with which the county has a contract (e.g., Union Rescue Mission). A senior county staff person indicated that they are attempting to increase the number of available contract beds. The geographic location of the facilities suggests that certain parts of the county are underserved, especially South County. Adding to the supply of beds is difficult, however, because conditional use permits must be obtained. In general, this has meant that shelters are located in unincorporated areas of the county.

Entitlements. One of the primary functions performed by the outreach team is to assist individuals in obtaining benefits, particularly SSI for the long term and General Relief in the short term. This stream of income is essential for giving individuals access to long-term housing arrangements. We were unable to obtain information on the number of successful applications for SSI that had been orchestrated by the outreach team, but we observed during our visit that the activity associated with this effort is a regular part of the duties of an
outreach worker. Reportedly the continuing care staff, from their involvement in the diagnostic assessments, is also helpful in assisting individuals in obtaining benefits.

Data was available from the one-month pilot project and this gives a sense of the disposition of cases. Of the 18 clients referred to the HMD program during the project period, all required assistance completing the GR form and 16 received help filling out the SSI application. A follow-up study conducted four months later found that: 5 had received GR; 4 had received SSI; 4 had SSI applications still pending (1 was placed using the Interim Placement Fund); 1 was approved for SSDI; 1 was working full-time; 1 was denied SSI; 3 had left the area (1 had been receiving unemployment, 1 was receiving GR, 1 had an SSI application pending). 6

Mental Health Services. The role of county mental health in delivering care to the HMD has been discussed above. County mental health services are targeted on the severely mentally ill. Most of these individuals require ongoing case management services from the Continuing Care Unit. Those requiring medications are also seen by Adult Treatment Services. Because medications supervision is conducted less frequently and may be less time consuming than therapy, the cases seen in the two units have different diagnostic characteristics.

Orange County does not own a county hospital, but contracts for all of its acute inpatient care. The only contract in an acute medical-psychiatric hospital is for 2.5 beds at Western Medical Center/Anaheim. The other county needs for psychiatric inpatient care are met through a combination of several levels of psychiatric skilled nursing facilities that have designations from the state as special treatment programs. There are 40 secure intensive inpatient beds with an average length of stay of 7 days at Royale Therapeutic Residential Center; 33 open beds with an average length of stay of 13 days in a subacute unit at Anaheim Therapeutic Residential Center; 48 beds with an average length of stay of 30-45 days in a subacute intermediate term program at Royale Therapeutic Residential Treatment Center. These

6Numbers may not add because individuals were counted in more than one category.
facilities serve both voluntary and involuntary patients. Individuals requiring longer lengths of stay may be transitioned to subacute or intermediate programs. Most discharges are reunited with their families and other supportive services; less than 5 percent of discharges are made to the HMD program.

Long-Term Housing Placements. Once a client has been brought into the mental health system, the Continuing Care Unit in the County Mental Health Clinic is responsible for follow up and case management, including placement of the HMD in board and care facilities. The HMD outreach team transfers a case to county mental health at the point when the client accepts services from the Continuing Care Unit; these clients are effectively considered "discharged" from the HMD program and are not typically followed up by the outreach team.

Orange County mental health relies extensively, although not exclusively, on board and care facilities for permanent placement of the mentally ill. County employees in the Continuing Care Unit, who are responsible for placing the mentally ill, are not authorized to place them in anything other than board and care. Individuals who wish other types of placement must arrange for their own living accommodations. Although there may be informal assistance offered, the thrust is definitely toward board and care.

County workers feel that the board and care system has adequate capacity. There are 838 licensed board and care beds available to the mentally disabled in 81 homes in the county; 702 beds in 55 homes have been certified for the supplemental rate program. During two weeks in September of 1987, about 40 vacancies for men and 48 vacancies for women were listed at the beginning of each week. This translates into a vacancy rate of about 5-6 percent, which is typically considered to indicate a system in a steady state (roughly equal numbers of individuals leaving housing as are seeking to enter).

Although the board and care system has vacancies, several observations are in order:

1) SSI is the key to obtaining board and care. The county has access to a revolving interim placement fund that can pay expenses while someone is waiting for SSI benefits, but these monies are generally available only to those who are likely to
obtain SSI. (Retroactive SSI payments are used to repay the Interim Placement Fund.)

2) The process of placing an individual in an appropriate board and care home involves some negotiation. All homes are not appropriate for all individuals. There is a particular problem with individuals who have been previously expelled from board and care homes for behavior problems; operators can simply choose not to accept these individuals in their homes.

3) There is a substantial range in the quality of board and care homes. Both the physical appearance and the "content" of board and care homes vary considerably. It was not possible to ascertain whether vacancies occur disproportionately in higher or lower quality homes.

County workers and supervisors alike believe that alternatives to board and care would be desirable. One possibility suggested was a two-tiered licensing system that would include more independent living situations.

Other problems associated with placement in long-term housing are the lack of options for low income housing and semi-independent living, and the lack of an adequate income stream. The latter is critical because it frequently takes between six and nine months to qualify for SSI, and General Relief is not sufficiently adequate to provide for permanent housing in most areas of the county.

In the early operation of the program, mental health officials estimated that up to 40 placements in long-term housing had been made for the HMO, a placement rate that was reportedly lower than expected. In a recent five-month period (July-November 1987), however, the number of persons placed in some form of permanent housing has reportedly increased significantly. Of 422 individuals served by the outreach team, 50 were reportedly placed in board and care, nine were placed in room and board, and 96 were placed in a mix of settings including family and hospital.
Effects on the Community

The program directors that we interviewed, as well as the county officials, indicated that the HMD program had not had a major impact on community attitudes toward the homeless. They believe that awareness of the problem is growing, but largely through education of the provider community.

One of the most notable ways in which the community has been involved in the program is through public hearings related to applications for conditional use permits. Orange County, like many other counties, has experienced some difficulties in implementing parts of its plan for the HMD because of problems in obtaining the appropriate conditional use permits. Although the County Board of Supervisors has supported the county efforts to establish programs for the HMD, city councils have been less likely to support such efforts. The result has been delays in acquiring locations for drop-in centers and shelters. The shelters are located in unincorporated areas of the county, and the only drop-in center currently operating is located in a YMCA which already held an appropriate conditional use permit. Although a considerable amount of time and energy is expended in the arena of public relations, the problem is unlikely to be resolved easily or quickly.

PROPOSED CHANGES AND PRIORITIES

In discussing with program directors and county officials possible changes that Orange County might consider making in its HMD program, three major themes emerged:

- Changes in the responsibilities of the outreach team
- New housing alternatives
- Greater coordination with other agencies
Changes to the Outreach Program

The Homeless Coordinator indicated that an increase in staffing levels would allow him to assign separate staff to the outreach and case management functions. The outreach team could be reaching greater numbers of individuals through all types of outreach if they were relieved of case management responsibilities. The case managers would also be able to undertake more comprehensive case management activities, including follow-up of individuals after "discharge" from the program.

The coordinator also favors satellite outreach units throughout the county under the mantle of the existing agency. For those working outside of the Santa Ana area, this would decrease the time spent commuting from the central office.

New Housing Alternatives

With increased funding, one respondent, a senior Department of Mental Health official, would favor increasing the number of crisis and transitional beds in order to reduce the amount of time spent in shelters and shorten the waiting lists for various types of housing. He believes that many individuals "fall through the cracks" because they cannot move forward to the next stage in the system of care.

Another respondent favors developing a residential treatment center on the psychosocial model. The facility would provide or coordinate in one location every service needed by an individual.

Greater Coordination with Other Agencies

Everyone we spoke with considered the pilot project outstationing a worker in the Santa Ana General Relief office to be a major success. The indication was that with additional resources this program would be maintained on a long-term basis and expanded to involve other similar agencies that have contact with HMD clients.

The Mental Health Association would like to see greater attention given to coordinating services for vocational rehabilitation and other job training opportunities. The possibility of linking up with a new program from Goodwill Industries was mentioned during our visit.
GAPS IN SERVICES

Interviews with staff personnel, as well as field observations, suggest several gaps in the continuum of services available to the HMD in Orange County.

Services for the Dual Diagnosis Client

One of the most difficult groups to serve are those with both a serious mental illness and a substance abuse problem. In the traditional service system, the mental health programs will not serve individuals who are intoxicated or high and the alcohol and drug rehabilitation programs may exclude those suffering from mental illness. These individuals often fall into the gap between programs, and those who do receive services may have difficulty benefiting from them because of the approaches taken. Drug and Alcohol Services tend to use a confrontational approach to push clients into recognizing and acknowledging their addiction and the need to do something about it. This confrontational approach is often too threatening to those with mental illness, particularly those with paranoia. On the other hand, while the mental health system tends to be more active in helping clients address other issues in their lives, such as basic subsistence, such an approach can contribute further to the dependency problems of addicts—"enabling" them to continue to engage in their addiction.

Orange County mental health and the county's Drug and Alcohol Services are working together to develop some programs for the dual diagnosis client. Targeted funding for such efforts would certainly increase the likelihood of actual program implementation.

Representative Payee Program

Orange County does not currently have a representative payee program. This causes problems for individuals whom SSI has determined cannot be their own payee. Without such an arrangement, these individuals cannot obtain SSI, and thus have a limited income stream for maintaining their living expenses. In particular, they do not have access to board and care facilities.
The dual diagnosed are especially affected by the lack of a representative payee program, because they are the most likely to have been deemed by SSI as not responsible enough to be their own payee.

Geographic Maldistribution of Resources

Most of the HMD program resources are located in the Santa Ana area. Although this area has the largest concentration of the homeless, other areas of the county, particularly South County, remain relatively underserved. In addition, all of the shelters are located around the Santa Ana area—and all are in unincorporated areas of the county, again because of the difficulty in obtaining conditional use permits in incorporated areas. Thus, if one of the outreach workers makes contact with an individual outside of Santa Ana, the person must "move" in order to be sheltered; outreach staff told us that many HMD are reluctant to relocate.

One of the policy dilemmas at the center of this problem is the claim that programs for the homeless act as a "magnet" for homeless individuals—that the supply of resources creates demand for those services. This is a difficult hypothesis to test. Certainly, programs raise the visibility of the homeless because of the concentration of individuals using particular services, and this is more noticeable in areas like Orange County where the homeless are more dispersed. On the other hand, if no services are available it might seem that there is no homeless population simply because their presence is not obvious.

Evening and Weekend Coverage

Evening and weekend coverage is fairly limited in Orange County, although the HMD program outreach team is on call during this time. However, the team does not have access to county vehicles after hours, and this limits the functions that the team can perform (e.g., transportation to services).

Whether this constraint poses any particular problems is uncertain. Because a major function of the outreach team is to link individuals with services, many of which are only available from 8 a.m. to 5 p.m.
during the weekdays, it seems reasonable that the outreach workers would have a similar schedule. The jail system notifies the outreach team or county mental health system in advance if they know a prisoner is going to be released over the weekend and does not have a place to go. However, advance notification by the hospitals, particularly in the case of involuntary holds, has been less reliable. Some HMD program and county staff expressed concern that some of these individuals were being released prematurely and without adequate discharge planning.

**Funding for Day Programs**

According to one of the senior-level county mental health staff, experience with both the drop-in center and the day programs run by county mental health underscores the need for daytime programs for the mentally ill. A major difficulty that this group faces is boredom because of the lack of structure in their lives. Although the availability of day programs can serve a variety of rehabilitation, socialization, and safety purposes, many of the smaller board and care homes are unable (or unwilling) to provide structured activities during the day. Funding for such programs has been extremely limited, and there are difficulties in locating sites for non-county-operated programs.

**Medical Care for Non-Life-Threatening Conditions**

Another gap in the system of services available to the HMD is medical care for conditions that are not life threatening. While the HMD who are currently receiving SSI are eligible for Medi-Cal, the remaining 60 percent are only covered under the indigent care provisions of the county. However, both systems have imposed utilization control measures that serve to limit access to services. In particular, tight county budgets have placed severe constraints on the availability of services for the indigent, generally restricting services to conditions that pose an immediate threat to life or that might result in permanent disability. The HMD reportedly suffer from a variety of medical conditions that do not fit into these categories and thus their access
to necessary medical care tends to be fairly limited. In one survey from the county, 34 percent of the HMD contacted by the outreach team had a physical health problem (e.g., eye infection, foot sores, malnutrition, pregnancy, back strain) that was not life threatening.
COUNTY CONTEXT

Demographic Profile

Yolo County is a lightly populated rural county in Northern California, lying adjacent to Sacramento County (see Table I.17 for demographic details). Most of the population lives in the communities of Davis, Woodland, and West Sacramento, which are separated from one another by 10 to 20 miles of farmland.

Davis is a relatively well-to-do community, although its median income is biased downward by the large student population attending the University of California at Davis. Homeless individuals are not readily observable on the streets. Two county mental health workers could recall only several occasions when homeless individuals were found wandering about, and the local police picked them up almost immediately and referred them to the Yolo County Department of Mental Health.

Woodland is more heterogeneous and generally less well-to-do than Davis; it contains both higher and lower income housing. A few apparently homeless individuals can be seen on the streets, but they are not congregated in any particular area.

West Sacramento, which has recently incorporated and is still often referred to as East Yolo, is distinctly impoverished, with a median income well below that of Davis and Woodland. This small community is situated on the banks of the Sacramento River, just opposite Old Sacramento, a redevelopment project built on the site of Sacramento's former skid row area. The riverbed between the two communities is notorious for its congregations of homeless individuals. The police have assumed a relatively high profile along the riverbed as a result of two recent murders there. They are currently trying to reduce the number of homeless individuals in that area by increasing their patrol activity and by warning individuals off private property.
Table I.17
YOLO COUNTY: SELECTED CHARACTERISTICS

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (1/1/86)</td>
<td>124,400</td>
</tr>
<tr>
<td>Three largest cities</td>
<td></td>
</tr>
<tr>
<td>Davis</td>
<td>40,550</td>
</tr>
<tr>
<td>Woodland</td>
<td>34,100</td>
</tr>
<tr>
<td>West Sacramento</td>
<td>27,000</td>
</tr>
<tr>
<td>Racial composition</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>81%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>17%</td>
</tr>
<tr>
<td>Black</td>
<td>2%</td>
</tr>
<tr>
<td>Median age</td>
<td>27.1</td>
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<tr>
<td>Per capita income</td>
<td>$10,693</td>
</tr>
<tr>
<td>(State average: $11,968)</td>
<td></td>
</tr>
<tr>
<td>Median family income</td>
<td>$20,495</td>
</tr>
<tr>
<td>(State average: $21,537)</td>
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</tr>
<tr>
<td>Income below poverty line</td>
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</tr>
<tr>
<td>Individuals</td>
<td>16%</td>
</tr>
<tr>
<td>(State average: 11.4%)</td>
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</tr>
<tr>
<td>Under age 18</td>
<td>12%</td>
</tr>
<tr>
<td>(State average: 15.2%)</td>
<td></td>
</tr>
<tr>
<td>Families</td>
<td>9%</td>
</tr>
<tr>
<td>(State average: 8.7%)</td>
<td></td>
</tr>
<tr>
<td>Unemployment rate (1986)</td>
<td>7.3%</td>
</tr>
<tr>
<td>(State average: 6.2%)</td>
<td></td>
</tr>
<tr>
<td>Residents eligible for Medi-Cal</td>
<td>11%</td>
</tr>
<tr>
<td>(State average: 11%)</td>
<td></td>
</tr>
<tr>
<td>Medi-Cal recipients</td>
<td>5.5%</td>
</tr>
<tr>
<td>SSI recipients</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

SOURCES: County Association of California, California County Fact Book, 1987; County and City Data Book, 1983, 10th edition.
Department of Mental Health

The mental health department's budget for FY 1986-87 was $5,186,748 (see Table I.18). The HMD allocation from the state was $109,991. The county provided an additional $12,221, which brought total HMD funding to $122,212.

The county mental health department has five administrative components: Administration and Support Services, Psychiatric Services, Adult and Children Services, Forensic/Jail Crisis Services, and Transitional Care. Adult and Children Services include adult and child outpatient care, as well as geriatric services and children's and adolescents' day treatment. The Forensic/Jail Crisis Services has a staff of 2.5 FTE, who respond to patient crises in the county that occur during regular working hours; and who form a liaison with the jails to divert inappropriate placement of patients in the criminal justice system. Transitional Care has a staff of six FTE who provide case management, day treatment, and the homeless program services.

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration</td>
<td>$130,771</td>
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<tr>
<td>Outreach services</td>
<td>579,191</td>
<td>11</td>
</tr>
<tr>
<td>24-hour services</td>
<td>2,250,201</td>
<td>43</td>
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<tr>
<td>Day services</td>
<td>986,559</td>
<td>19</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>923,867</td>
<td>18</td>
</tr>
<tr>
<td>Continuing care</td>
<td>316,159</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,186,748</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

County Homeless/HMD Population

In its proposal for HMD funding, the mental health department estimated that there were approximately 250 homeless mentally disabled in the county. The proposal describes the basis for the estimate as follows. First, the department surveyed the county's service providers to derive an estimate of the total number of homeless. (The proposal describes the services rendered and the number of homeless served, but does not explain how these numbers were used to derive a total count of homeless and does not report that total.) The department then derived the number of homeless mentally disabled individuals by assuming that 30 to 40 percent of the homeless population is chronically mentally ill.

Another estimate of the homeless population was developed by the county's Homeless Task Force, which was organized about the time the HMD program became operational in Yolo County. The task force surveyed seven programs operating in Yolo County during May 1986; the survey defined homeless individuals as "persons without a home or in a receipt of an eviction notice." They found that the programs served between 256 and 448 homeless individuals during May 1986. The task force count did not include "street people" who do not use services. If we again assume that up to 40 percent of the homeless individuals served by the agencies are chronically mentally ill, then the task force estimates would range between 100 and 180 HMD in the county.

Opinions about the accuracy of HMD estimates vary. When asked during our site visit if the HMD estimate of 250 persons was still accurate, an outreach worker responded that the number probably remained constant as new individuals joined the ranks of the homeless, thus offsetting the gains made by placing homeless clients into permanent housing. However, during a telephone interview an official from the department of mental health stated that he thought the HMD population was probably larger, but no new formal estimates have been made.

Trying to count the homeless mentally disabled in the county will always be a problem. Although the largest HMD population congregates along the riverbed, service providers in both Yolo and Sacramento counties note that these individuals regularly cross the bridges
connecting the two counties and use services on either side. Because Yolo County and the City of Sacramento share a common boundary, there will be large fluctuations in the number of homeless in Yolo County at any given time.

Pre-HMD Program Activities

Before passage of the HMD legislation, the county had organized a Homeless Network consisting primarily of representatives from the various county and community-based organizations working with the homeless. The network's purpose was to improve the coordination of services and the allocation of funds among providers. It also set about reviving the Wayfarer Mission, a shelter and food resource for the homeless that was having financial difficulties. In spring 1986, with the advent of the HMD program, the network was reorganized and renamed the Homeless Task Force. The organization increased its membership, including representatives from the Mental Health Association, from the Woodland Ecumenical Ministries, and from the public. One of its first activities was to publish a report outlining current service provisions and identifying gaps in service.

The report of the Homeless Task Force and the county's proposal to the state describe the services already in place and their utilization statistics. They report that during 1984, the Wayfarer Mission served a total of 130,960 meals for the poor and provided 21,900 person-nights of shelter. Although the mission closed temporarily, it reopened coincident with the arrival of HMD funds in April 1986. The Short-Term Emergency Aid Committee spent $50,000 on food and shelter vouchers in 1984, and $55,000 in 1985. To indicate the difficulty of finding affordable housing in Yolo County, they noted that in February 1986 the County Housing Authority had a waiting list of 1500 people. The General Assistance housing allowance was $100 a month, although most single rooms in the county were renting for about $200 a month.

The Yolo Community Care Continuum, established in 1979, provides a wide range of services for the mentally disabled. The agency's socialization center in East Yolo had 16 homeless clients immediately prior to the introduction of the HMD program.
A suicide prevention/mobile crisis intervention program was also in
operation prior to the HMD program and was serving an increasing number
of homeless individuals.

When the Yolo County Department of Mental Health set out to
determine how the HMD funds should be allocated, it found itself
involved in community discussion and deliberation lasting several
months. One respondent described the situation as a vigorous struggle
among the various agencies over the division of funds.

IMPLEMENTATION OF THE HMD PROGRAM

Overview of the HMD Program

The county already had many service providers in place, so the
missing component of an effective HMD program seemed to be a mechanism
for establishing ongoing contact with these individuals and linking them
to the available services. Consequently, in allocating the HMD funds,
the department of mental health chose to emphasize outreach. The
outreach workers echo the stated county intent. They see their
immediate goal as providing basic services and stabilizing the living
conditions of the individual.

The HMD program in Yolo is intended to serve both homeless
individuals and those at risk of homelessness. One outreach worker
estimated that those served are divided about equally between the two
groups. Data seem to support this estimate. In West Sacramento, out of
81 clients served between February 1986 and the end of September 1987,
56 were homeless and 25 were at risk. In Woodland/Davis during the same
period, 20 homeless adults and children and 17 adults at risk of
homelessness were served.

Figure 1.3 provides a schematic overview of the HMD program in Yolo
County. The arrows in the diagram indicate the directional flow of the
homeless.

The outreach team forms the heart of the program. The team's
responsibilities include engaging individuals; providing for their
immediate and basic needs; and linking them to long-term services such
as financial assistance and benefit programs, permanent housing, and
mental health services. The team's most important function is to ensure continuity of care by determining what services each individual needs, and taking whatever steps are necessary to obtain them. The outreach team maintains contact with each client even after he/she is stabilized in housing and has a regular source of income. Although the contact becomes less frequent, the occasional visits potentially enable the outreach workers to prevent a return to homelessness because of eviction or problems with social security benefits or money management.

The outreach workers make contact with their clients in three primary ways: (1) active outreach, (2) client self-referral, and (3) referrals from other service and community agencies. In the case of client self-referral, the individual need only walk into one of the socialization centers. In the case of agency referral, the referring agency can contact either County Mental Health (see Fig. I.3) or an outreach worker in one of the socialization centers. The shelter in Woodland, for example, both refers clients to and receives clients from the outreach team.

Linkage between the various service providers and the outreach team is facilitated by the team's unique organizational structure. One of the three outreach workers is employed directly by the county department of mental health, which naturally creates a strong link between the two units. The other two outreach workers are employed by the Yolo Community Care Continuum, an agency under contract to the department of mental health. Among other services, this contracted provider operates three socialization centers (not funded with HMD funds); and the two outreach workers have offices in the socialization centers, which serve as their home base for providing services to their homeless clients.

After the first contact with their homeless clients, the first priority of the outreach team is to get them into temporary shelter and to provide food and other basic necessities. The county has several temporary shelter facilities: a crisis residential house, a 6-bed shelter for men, and two "mental health cabins." The outreach team can also place individuals in motels as needed.
Fig. I.3--Schematic overview of services for the HMD in Yolo County
The next step is to help clients obtain General Relief and Social Security benefits. General Relief support is usually available within three or four weeks; obtaining Social Security benefits takes much longer.

After attending to the financial concerns, the outreach workers help clients to find permanent housing. The county has two board and care facilities (11-bed and 4-bed), a 9-bed long-term residential program, and a halfway house for the mentally disabled. These residential programs either operate at capacity or are too structured for their clients, so generally the outreach workers try to place their clients in apartments. The workers have developed a rapport with a number of landlords in the county and often have several clients in any given complex.

Depending on a client's initial condition and cooperation, the outreach worker may refer him/her to County Mental Health. As necessary, the individual may be given prescribed medications, which will be monitored by a County Mental Health case manager.

County Mental Health offers a number of services for the HMD. Under its subpayee program the department receives SSI payments for the client, then provides the appropriate level of money management. The county mental health department also offers ongoing case management, therapy or day treatment, and time-limited therapeutic counseling.

Even after a client is successfully linked to county mental health services, the outreach worker maintains contact with the client and works to ensure continuity of care.

Other mental health services are available to clients through the Yolo Community Care Continuum, a large mental health organization with an agency budget of over $1 million. The Continuum includes 3 socialization centers, a 6-bed crisis residential facility, a 9-bed long-term residential farmhouse, a 6-bed halfway house, and a vocational program. The Continuum, which does not receive any private funding, was organized in 1979, tapping into the Bate's categorical funding legislation that funded agencies providing a continuum of care for the mentally disabled. The East Yolo and Woodland/Davis outreach workers
are employed by this agency and have offices within the socialization centers; the link between the outreach team and the socialization centers is especially strong.

Another potential route into the homeless program is through the Suicide Prevention/Mobile Crisis Intervention programs, which respond to critical situations after hours and over the weekend. The Suicide Prevention program operates a hot-line, primarily to prevent suicide. In addition, the mobile crisis program provides someone to respond to critical situations occurring after hours and over the weekend. For example, it might be called to handle a mentally disabled individual who was causing a disturbance. Depending on the level of the crisis, Mobile Crisis might initiate a 5150, and the hospital discharge planner would assume responsibility for the individual; or the crisis team might give the person a motel voucher and refer him/her to an outreach worker in the morning.

Table I.19 indicates how HMD funds were allocated across services. Outreach efforts, the core of the program, received 71 percent of the funds. Basic services, primarily food and shelter, accounted for 17 percent of the budget. Contractors were allocated 60 percent of the budget; the remainder was used to pay the 1.5 FTE salaries of the county outreach worker and a subpayee administrator.

According to the county fiscal administrator, the county spent about 40 percent of its allocated funds in the first year of funding (FY 1985-86). The county spent 100 percent in the following year.

The shelter program, Mobile Crisis, and the voucher system--all of which began using their HMD funds by spring 1986--spent 100 percent of their allocated funds in the first year. The Yolo Community Care Continuum, which employs two of the three outreach workers, spent 66 percent of its first-year allocation. The next year all programs spent their full allocation.
Table I.19
HMD PROGRAM BUDGET ALLOCATION, 1987

<table>
<thead>
<tr>
<th>Item</th>
<th>Amount</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>County services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach</td>
<td>$41,286</td>
<td>34</td>
</tr>
<tr>
<td>Substitute payee administration</td>
<td>7,476</td>
<td>6</td>
</tr>
<tr>
<td>Contract Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach</td>
<td>45,450</td>
<td>37</td>
</tr>
<tr>
<td>Shelter</td>
<td>10,000</td>
<td>8</td>
</tr>
<tr>
<td>Food/motel vouchers</td>
<td>10,000</td>
<td>8</td>
</tr>
<tr>
<td>Mobile crisis</td>
<td>8,000</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>$122,212</td>
<td>100</td>
</tr>
</tbody>
</table>

SOURCE: Letter from Yolo County Department of Mental Health, July 28, 1987.

Organization and Management

The HMD program is administered by two county staff members: a Fiscal Administrator, and a Transitional Care Coordinator, who is responsible for clinical considerations. The Fiscal Administrator reviews and approves expenditures and visits program sites at least once a quarter. The Transitional Care Coordinator reviews clinical charts, visits program sites every two months, and conducts a formal evaluation once a year. The Transitional Care Coordinator also chairs regular meetings of the Homeless Support Team, which includes all of the outreach workers, and the directors from the Continuum, the Wayfarer Mission, and the Short-Term Emergency Aid Committee, and has telephone conversations with members of the homeless team about every other day. The Transitional Care Coordinator investigates any complaints and reviews fiscal matters with the Fiscal Administrator.

The department of mental health evaluates the HMD providers on an ongoing basis. Although its reporting requirements do not extend beyond those required by the state, the department maintains continuous contact with the personnel of the programs on both a formal and informal basis.
The county does not provide any formal training for the HMD staff, but any problems are resolved as they arise in collaboration with either the Transitional Care Coordinator or the Continuum director. The homeless team meetings also provide a forum for discussing problems.

The county contracts out with four different agencies for outreach, shelter, mobile crisis, and food/motel vouchers. These agencies have been operating from 5 to 23 years (see Table I.20). HMD funding represents only a small proportion of their total funding, and three out of four receive up to 50 percent of their funding from private sources.

PERSONS SERVED
Overall Program Activities

Table I.21 provides summary statistics for overall HMD program activity in December 1986 and March and June 1987. Referrals have dropped in March to half of what they were in December, but the total amount of services provided remains comparable. The statistics also reflect only the use of shelter beds; they do not include the outreach team's use of permanent housing. Preferring to place individuals in the least restrictive setting, the team places clients in apartments (it has placed two clients in board and care facilities out of the county to be followed by the Yolo case manager).

To obtain a better understanding of the type of referrals made to and by the outreach workers, we asked the Woodland/Davis outreach worker to record all such referrals during a week in August 1987 and a week in November 1987. In the last week of November, which she noted as particularly quiet, the Woodland/Davis outreach worker referred one client to a shelter, one to independent living, and one to vocational skills services. All of these clients were referred to her from the Yolo Community Care Continuum Crisis Residential House.

The week in August was more active. Ten clients were seen during that week, including two new clients. All ten clients were referred to some services. She worked with five to obtain SSI entitlements and one to obtain General Relief; two obtained shelter and other services. Eight clients received other unspecified services. Five clients were
Table I.20
CHARACTERISTICS OF HMD PROGRAM CONTRACTED AGENCIES

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Wayfarer Mission</th>
<th>Yolo Continuum</th>
<th>Mobile Crisis</th>
<th>Emergency Aid Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year began</td>
<td>1962</td>
<td>1979</td>
<td>1965</td>
<td>1967</td>
</tr>
<tr>
<td>Annual Budget</td>
<td>$100,000</td>
<td>$1,000,000</td>
<td>$146,000</td>
<td>$73,109</td>
</tr>
<tr>
<td>Percent HMD funds</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Percent private funds</td>
<td>50</td>
<td>0</td>
<td>30</td>
<td>50</td>
</tr>
<tr>
<td>Type of services</td>
<td>Basic services</td>
<td>Residential care, vocational/rehabilitation, day centers, suicide prevention</td>
<td>Crisis intervention/ suicide prevention</td>
<td>Administration of food and motels</td>
</tr>
<tr>
<td></td>
<td>for homeless</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table I.21
YOLO COUNTY OVERALL HMD PROGRAM ACTIVITIES

<table>
<thead>
<tr>
<th>Activity</th>
<th>December 1986</th>
<th>March 1987</th>
<th>June 1987</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unduplicated clients</td>
<td>77</td>
<td>95</td>
<td>96</td>
</tr>
<tr>
<td>Average # beds used</td>
<td>11</td>
<td>9</td>
<td>11</td>
</tr>
<tr>
<td>Average # meals served</td>
<td>60</td>
<td>33</td>
<td>68</td>
</tr>
<tr>
<td>Assessments</td>
<td>153</td>
<td>61</td>
<td>46</td>
</tr>
<tr>
<td>Referrals</td>
<td>54</td>
<td>26</td>
<td>36</td>
</tr>
<tr>
<td>Shelter</td>
<td>54</td>
<td>54</td>
<td>48</td>
</tr>
<tr>
<td>Food</td>
<td>70</td>
<td>95</td>
<td>96</td>
</tr>
<tr>
<td>Clothing</td>
<td>--</td>
<td>38</td>
<td>--</td>
</tr>
<tr>
<td>Financial support</td>
<td>--</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Money management</td>
<td>6</td>
<td>33</td>
<td>23</td>
</tr>
<tr>
<td>Psychotropic medication</td>
<td>--</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Mental health day services</td>
<td>30</td>
<td>27</td>
<td>40</td>
</tr>
<tr>
<td>Mental health outpatient</td>
<td>--</td>
<td>13</td>
<td>1</td>
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<tr>
<td>Mental health 24-hour care</td>
<td>--</td>
<td>34</td>
<td>--</td>
</tr>
<tr>
<td>Case management</td>
<td>62</td>
<td>11</td>
<td>43</td>
</tr>
<tr>
<td>Involuntary hospitalization</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Transportation</td>
<td>23</td>
<td>30</td>
<td>44</td>
</tr>
<tr>
<td>Board and care placement</td>
<td>--</td>
<td>--</td>
<td>1</td>
</tr>
</tbody>
</table>

SOURCE: County reports to the State Department of Mental Health.

NOTE: Figures represent the cumulative level of activities over a one-week period during the month indicated.

referred to her by County Mental Health, three from the Wayfarer Mission, and two from the Yolo Community Care Continuum Crisis Residential House.

Because there is no point at which an outreach worker passes responsibility for a client on to another agency, an increased number of client contacts means an ever increasing caseload for the outreach workers. At the time of our site visit, their caseload had not yet become burdensome, but it is a potential problem.
Client Characteristics

By reviewing their caseload, the outreach workers were able to provide information about their clients' characteristics.

The county outreach worker noted that of 25 clients served in May 1987, 14 had a major mental illness (Axis I) while 10 were identified as minor diagnoses. Half of the clients were female. The East Yolo outreach worker had 40 percent female clients.

In Woodland/Davis, of 62 clients served between February 1986 and October 1987, 31 percent were schizophrenic, 19 percent were depressed, 11 percent were bipolar, 10 percent had organic brain syndrome, and 27 percent were identified as dual diagnosis.

The Wayfarer Mission could not provide client characteristics separately for the HMD clients. For their entire clientele of 196 persons served from January through September 1987, 30 percent were female, 83 percent of the clients were white, and 13 percent were Hispanic. The mission staff identified 35 percent as mentally disabled and 43 percent as primarily substance abusers.

PROGRAM ACTIVITIES

The preceding discussion explains how the Yolo County homeless program works in general. To understand in more detail how the program works, it is useful to know where the service agencies are physically located and how this geography affects the service provisions. Therefore, in the discussions below, the services provided in Woodland and Davis will be considered separately from those provided in East Yolo.

Outreach

Seventy-one percent ($86,735) of the HMD funds are allocated to outreach. The three outreach team members are funded with HMD funds, one directly through the Yolo County Department of Mental Health, the other two contractually through the Yolo Community Care Continuum. The county outreach worker, who has an MS in nursing, was hired by the county during the implementation of the HMD program. She is responsible
for outreach to county-wide homeless programs, and travels throughout the county, working with clients as well as bringing together community resources to help clients (for example, contracting with a hospital for its surplus meals). She works in collaboration with the outreach worker responsible for East Yolo to manage the large caseload in that community. The Woodland/Davis outreach worker has a BA and MA in psychology and was also hired by the Yolo Community Care Continuum at the time that the HMD program was implemented. The East Yolo outreach worker has a BA in journalism with a minor in psychology. This individual was employed by the Yolo Community Care Continuum prior to the HMD program and was the coordinator of the East Yolo socialization center.

Active outreach is conducted regularly in East Yolo, and is concentrated along the bed of the Sacramento River. This direct outreach accounts for about 43 percent of the East Yolo caseload. In contrast, although the county outreach worker does actively engage some clients, active outreach is not conducted on a regular basis in either Davis or Woodland. This probably does not lead to underservice of more severely disabled individuals because not much in the way of abnormal behavior can occur in these communities without it immediately coming to the attention of the homeless team through referrals.

Active outreach usually begins by offering a potential client food or toiletries. Additionally, the East Yolo outreach worker may take the client to a restaurant, which has proved helpful in engaging individuals in further conversation. This worker believes it is very important to get clients to come to the socialization center where the most powerful outreach can occur, because there the new client can see how other mentally disabled individuals have succeeded. Another successful strategy for sustaining contact with individuals has been to ask them for help in various ways, such as cleaning apartments or moving furniture. Since the beginning of the HMD program, the outreach worker could recall only a single individual whom he was unable to engage.

Clients also enter the HMD program by walking into a facility or by being referred by other agencies. In East Yolo, 19 percent of the clients walked into the socialization center looking for help. Another
17 percent were referred to the East Yolo outreach worker by other agencies. In Woodland/Davis, 17 percent of the adult caseload were self-referrals, and 83 percent were referred by other agencies. A primary referral source in Woodland—accounting for about 40 percent of the caseload—is the Wayfarer Mission, which provides food, clothing, and other basic services to the general homeless population. The Crisis Residential House administered by the Yolo Community Care Continuum accounts for another 15 percent, and 13 percent are referred by the county mental health department.

All of the outreach workers are very hesitant to initiate 5150s. An individual committed involuntarily is usually taken to Yolo General Hospital in Woodland. Because the hospital is situated some 20 miles from West Sacramento, the MND experiences substantial displacement when he or she is released. The outreach workers believe that clients who have been involuntarily hospitalized may be harder to reach in the future, and that the process alienates potential clients. The workers are determined to avoid using the 5150 process until they can be sure of a more positive outcome for their clients.

Intake and Screening

After initially engaging a client, the outreach worker’s first priority is to provide basic food and shelter subsistence. The worker screens the individual to determine if he or she is mentally disabled and to obtain the information necessary for serving the client. The criteria for determining mental illness are past history, medications, and existing symptoms of mental illness. If a client is seeking psychiatric help, the county outreach worker conducts an immediate assessment. Clients who are not mentally ill are referred to other homeless services. Because a general shelter for the homeless is not available in East Yolo, these individuals are referred elsewhere.

The outreach workers are unable to help MND individuals with shelter who are actively using drugs or alcohol. They can only provide such individuals with food and other basic items. The only shelter that can be provided is at a detoxification facility.
As part of the implementation of the HMD program, Intake forms and service plans were designed for the outreach workers to use. The Intake form collects basic demographic, financial, physical, and mental health information. The service plan allows space to describe the client's immediate needs and any actions taken both in the short-term and long-term. It also has a checklist of agencies to which the client may be referred, and asks whether the services were used.

Case Management

In Yolo County, case managers serve as the client's primary therapist. The outreach workers are not classified as case managers, but perform many similar functions. The outreach workers assess their clients' needs and work with their clients on a continuing basis, maintaining daily contact until such time as their clients begin to stabilize. After this occurs, the intensity and frequency of contact will depend on the needs of each client. The outreach workers maintain contact on a monthly basis with every client ever engaged for as long as the client remains within the county. By assuring that relationships with landlords, neighbors, and "significant others" such as roommates are working smoothly and by keeping a close eye on money management, the workers hope to prevent any crisis that might lead to eviction or present other problems for the client.

The outreach workers in Yolo County do not give up on a client unless the client completely rejects their services or moves out of the county. Since Yolo is a rather small county, and because the outreach team has established a good working relationship with the various service agencies, client contact on a continuing basis is a reasonable expectation and possibility.

Drop-In Centers

The Yolo Community Care Continuum operates three drop-in socialization centers: the Lighthouse, the Haven House, and the East Yolo House. Although the socialization centers are not formally funded by the HMD program, the two outreach workers have offices in these
centers and this encourages their clients to use them. The centers are really houses and have kitchens and bathrooms. They are specifically intended to be day socialization facilities for the mentally disabled, which can be attended by clients on a drop-in basis. Clients who use the socialization centers have charts opened for them and service plans prepared, and the charts and service plans are reviewed every six months. Parties on special holidays bring together clients from all of the socialization centers and from other Continuum programs.

Of the three socialization centers, the Lighthouse in Davis is the least likely to be visited by formerly homeless clients. All of its 35 members are mentally disabled. Although one or two of its clients may have originated from the homeless program, all of its current clients have homes; and of these, only 5 to 6 live in one board and care facility.

At the East Yolo House, 40 percent of the clients came from the homeless support network. This house is much more informal and hectic, and is located in a much poorer area.

The Haven House in Woodland has about one new client a month. During September 1987, there were 342 total visits with 45 unduplicated contacts. Eight to 10 of the clients came from the HMD program.

Financial Assistance

After shelter and food, the next priority of the outreach workers is to help their clients obtain General Assistance, food stamps, and Social Security benefits. Out of 41 adult clients, the Woodland/Davis outreach worker helped 9 clients to obtain General Assistance and food stamps, and 7 to file SSI applications. The West Sacramento outreach worker had helped 9 of 31 clients obtain SSI benefits. The number of clients at these locations who were already receiving income benefits was not readily available.
Mobile Crisis

The mobile crisis program is primarily a suicide prevention program. One staff member is on call after 5:00 p.m. and over the weekend to respond to various crises. The agency was organized in 1965 and has a total budget of $146,000; the mobile crisis program was added in 1981. One-third of the funding comes from private sources. Half of the agency funding directly supports the mobile crisis unit, the other half is targeted toward community outreach and education. Since the implementation of the HMD program, the mobile crisis program has been able to provide food and housing vouchers to homeless clients. From January to March in 1985, 80 of 312 face-to-face interventions were with homeless individuals.

During the three months from April to June in 1987, the mobile crisis program had 28 phone calls lasting over five minutes. The average length for these phone calls was about an hour. The program also had 205 face-to-face contacts, averaging over an hour in duration. The primary client problems were depression, psychotic symptoms, and drug abuse. Sixty-four percent of the contacts were from Woodland/Davis and 26 percent were from East Yolo. Twenty-seven percent of the clients were referred to County Mental Health, 23 percent to Yolo General Hospital, while 16 percent required no referral. Nine of the clients during the three-month period were homeless.

Shelters

Until General Assistance or some other entitlements are available, the outreach workers place clients in a temporary shelter. The Wayfarer Mission in Woodland operates a 6-bed men's facility and bills the Yolo County Mental Health Department on a fee-for-service basis for sheltering HMD clients. Shelter is available on a two-week basis, with the possibility of a two-week extension. The mission's total budget is about $100,000, with 50 percent coming from private sources. Budget expenditures are about equally split between shelter and food. The mission serves both the homeless (about 90 percent of its clientele) and the at-risk population, providing bags of groceries for the latter.
About 50 percent of its total clientele are HMD, and about half of these individuals are considered severe (Axis I). The mission began operations in 1982 as a shelter for the homeless, housing about 60 individuals a night in a thrift store. It closed down temporarily due to financial difficulties, but then reopened in April 1986. A 6-bed women's shelter was planned for the end of 1987.

The Yolo Community Care Continuum operates the Safe Harbor House in Woodland, a 24-hour short-term crisis residential facility with 6 beds. Its primary purpose is to stabilize clients. Over a six-month period prior to the implementation of the HMD program, 42 percent of the clients were homeless and 32 percent were at risk of homelessness.

In East Yolo the socialization center supervises two "mental health" cabins for temporary shelter paid for by Short-Term Emergency Aid Committee. These two stand-alone apartment units are located across the street from the center, and each unit can accommodate up to four persons, depending on the mix of men and women and the nature of their mental illnesses.

In addition to these specific facilities in Woodland, Davis, and East Yolo, food and motel vouchers are available to the homeless team through the Short-Term Emergency Aid Committee. In 1984, funds from this agency provided for 9,107 shelter nights and 35,355 meals. East Yolo accounted for 50 percent of this activity, and Woodland and Davis for 30 percent and 20 percent respectively. Currently, the total budget for this agency is $73,109. About half of the budget will be spent on shelter vouchers, the other half on food. United Way funds about 50 percent of the budget, and the rest comes from FEMA grants and the HMD program.

County Mental Health

The Yolo County Department of Mental Health follows a community mental health model. In describing the intent of the HMD program, one respondent stated that the county wants to "provide treatment and maintenance as best we can, especially for those who haven't before availed themselves of needed services and are resistant to doing so." This is achieved by organizing basic subsistence programs, by helping
clients obtain SSI benefits and housing, and by providing therapy, case management, and medication. Department staff believe it is important to provide medication for the homeless mentally disabled as soon as possible, so that symptoms can be stabilized while other assistance programs are being negotiated.

Ideally, individuals in crisis are brought to the psychiatric inpatient unit at Yolo General Hospital or Safe Harbor, which are located in Woodland. Once there, the patients are stabilized on medications; then a discharge planner makes arrangements for the patient's release and coordinates the release with a county case manager in the department of mental health. The case manager then follows up with the client and assumes responsibility for maintaining the patient's medication regimen and therapy.

The case managers with the county department of mental health each carry an average caseload of 55 clients. The role of county case management has not changed formally with the implementation of the HMD program, except for the size of the caseload and the types of service needs. They now see more clients with concerns relating to housing placements and money management. Of the 228 case management clients, 24 were referred by the homeless outreach team.

Immediate access to county case management is available only in a crisis situation. One respondent estimated that it takes about 3 to 4 days for a homeless client to get into the mental health system, and that only about one of every five homeless mentally disabled clients they serve end up receiving county case management.

Of the 32 of the clients with whom the county outreach worker worked in May 1987, 7 were brought into the county mental health system, while 8 were already in it. The Woodland/Davis outreach worker referred 16 out of 26 clients (35 percent) to County Mental Health. So although not everyone gets linked into the county mental health system, about one-third to one-half do get into the system.

The county department of mental health also administers a subpayee program with HMD funds. The subpayee program is currently serving 8 clients and has a capacity for serving 35.
Residential Treatment and Housing

After a client has obtained a source of income, the outreach workers will help the individual find permanent housing. About one-third of the clients in the outreach workers' total caseload are placed in permanent housing. Another one-third are housed but are considered at risk of homelessness. And the final one-third are out of contact with the outreach team (in the great majority of cases because they have left the county).

The length of time required to stabilize a client in long-term housing is extremely variable. Depending on the individual, it may occur almost immediately or take as long as a year. Some clients may cycle through temporary housing several times before they can be effectively stabilized.

There are three types of permanent housing in which an outreach worker can place an HMD client: apartments, board and care, and the residential programs of the Yolo Community Care Continuum.

The conceptual model for the Yolo Community Care Continuum calls for the Continuum to help the mentally disabled individual live in the least restrictive setting possible, and to help individuals be a part of the community in which they live. The idea of the Continuum is to provide all of the necessary steps along the way to the goal of socialization and independent living, and the largest share of their funds is targeted toward residential care—in particular, staffing the crisis residential and long-term transitional houses. The Continuum begins with the crisis residential house, which helps stabilize an individual in crisis. The next step is a fairly remote farmhouse, the site of the long-term transitional facility. With a maximum two-year stay, the purpose of this facility is to help individuals work toward earning increased freedom by demonstrating increased social responsibility. The halfway house in Davis is the next step. Here, individuals work and live in the community but still receive some residential supervision. The Continuum also includes vocational training for individuals with sufficient motivation to seek self-sufficiency.
The clients engaged by the homeless team rarely enter either the long-term or transitional housing programs or the vocational training program. Only one person had been accepted in the vocational program, and one other had stayed at the Farmhouse (the long-term facility). No clients from the homeless program have stayed at the halfway house. The director of the vocational program and the East Yolo outreach worker both believed that a client would have to be stabilized for about three years before the individual would be sufficiently stabilized and motivated for the vocational program. In addition, the remoteness and structured approach of the Farmhouse does not make it a truly viable option for HMD clients.

As mentioned earlier, the outreach workers prefer to place clients in the least restrictive setting. They, therefore, prefer to place individuals in apartments rather than in the board and care facility or the Continuum's residential programs.

Not all HMD are willing to accept permanent housing. The county outreach worker noted that out of 31 clients worked with in May 1987, two were homeless by choice. In a similar vein, of the 81 clients the East Yolo outreach worker worked with since February 1986, five remained unwilling to accept housing. The Woodland/Davis outreach worker had one out of 46 clients who was intent upon remaining on the street.

EFFECTS OF THE HMD PROGRAM

We now turn to an assessment of the HMD program's effects on service coordination, ability to target and serve the HMD, and community perceptions.

Coordination

The HMD program has improved coordination of services in Yolo County, according to individuals responding to our telephone interviews. A high level of coordination had been attained through the Homeless Task Force prior to the HMD legislation, but the development of an outreach team and the Homeless Support Team contributes to the coordination across agencies.
The Homeless Support Team consists of the Transitional Care Coordinator, program directors, and the outreach team members. Regular meetings allow the team to deal with general problems that may arise, as well as the specific details of a particular client.

The outreach team also enhances coordination by taking full responsibility for ensuring the continuity of care. Each client has an assigned outreach worker, so each agency knows who to contact with regard to that particular client. In the event of a potential crisis, a landlord would also know to contact the outreach worker. And the fact that the county is small increases the outreach team's ability to interact closely with the community in general.

Coordination between County Mental Health and the outreach team is also increased by including a county staff member in the outreach team. The county outreach worker networks across the whole county, bringing together community resources to help the HMD while actively working as a part of the Yolo County Department of Mental Health.

Targeting and Engaging the HMD

Everyone interviewed felt that the program was targeting specifically on the HMD population. Almost everyone agreed that the program was successful at serving the more severe cases. Most of the agencies involved in the HMD program were serving the mentally disabled prior to the HMD legislation. As a result, these agencies already have the expertise to distinguish the mentally disabled from the general homeless population. The outreach workers in particular are especially attuned to working with this population. A number of the HMD engaged by the program were retained on a long-term basis and transferred to standard case management when stabilized. However, one respondent pointed out that the homeless program was beginning to cost too much, and that the county might have to begin limiting its services.
Serving the HMD Population

The consensus among those interviewed was that the HMD program had been quite successful at serving the HMD population. The Woodland/Davis outreach worker has served 62 clients since the program began, while the East Yolo outreach worker has served 81 clients. About one-third of these clients are at risk of homelessness, while another third are lost to the HMD program when they leave the county. However, the remaining third are placed in permanent housing. About a third of all clients are already using the county mental health system, and another third are brought into the system. At any point, the outreach workers have a few clients who are currently resisting both mental health and housing services.

Effects on Community

In discussions of how the HMD program may have changed community attitudes, respondents expressed a positive view. The program has provided positive publicity for the homeless mentally disabled, and has also helped the homeless in general by increasing the awareness of the public about specific homeless subpopulations, such as homeless families and the new homeless. The program was seen to have led to an increased willingness of people to help the transient population. Nevertheless, at least one respondent was concerned that the homeless in general may not benefit by being suspected of being mentally ill.

PROPOSED CHANGES AND PRIORITIES

When asked what changes they might make in the HMD program, the consensus among the service providers was that they were glad for the funding they had but could certainly use more. The former director of the Wayfarer Mission noted that even a 50 percent increase in her allocation ($5,000) would not be enough to make a true impact on her program. In general, everyone noted that transitional housing was still a major service gap for the county, and that it would be the most appropriate target of additional funding.
Mental health officials thought that the flexibility of the HMD program was an advantage, bringing "more bang for the buck." The county used the funds for a wide variety of activities and helped develop collaboration, which was thought relatively easier to do in a small county. With additional funds, more help would be provided to shelter programs and transitional housing. It was noted that some of the administrative costs (such as travel between communities by the county outreach worker) had not been separated out for consideration under the HMD program.

One respondent thought that follow-up studies should be undertaken to address the questions of whether the county is breaking the cycle of homelessness and what the results of their efforts have been. Should it add vocational and rehabilitation programs? And what are the best ways to maintain individuals on a long-term basis? The same respondent would use additional funding to conduct more outreach and to concentrate more on residential programs and case management, so that the county could get more individuals into services and maintain them.

Finally, there was general consensus that housing was a real problem, and one that the HMD program did not fully address.

GAPS IN SERVICES

Transitional Housing

Everyone interviewed considered transitional housing to be a major gap in services for the county. Short-term shelter in East Yolo is scant, but does exist in the form of two cabins. The Woodland/Davis area can draw on the Wayfarer Mission or the crisis residential house for sheltering individuals on a short-term basis. The only available housing with support staff is the 9-bed Farmhouse and the Sihaya halfway house. As a result, the outreach team works to place clients directly into apartment living as the next step in residential living.

The HMD program would benefit from the availability of transitional housing with a less structured programmatic approach. The Farmhouse is a highly structured program emphasizing socialization and pre-vocational training located in a physically remote area. While successful with the
clientele it does serve, a less remote and less structured program might be more accessible and appropriate for the HMD clients.

Salaries

One respondent mentioned that a priority for additional funding would be to increase the salaries of the outreach workers. They now receive $13,000 with no expectation of increases. Such a salary unfortunately ensures a high turnover rate among the outreach workers, regardless of the individual's dedication. Because the outreach workers provide the link between the clients and the service agencies, a high turnover threatens both the quality and continuity of care for the HMD.

Follow-up calls to the outreach workers revealed that one outreach worker had indeed moved on to another job, and the other was to be leaving soon. Salary was the stated reason for leaving. The worker expressed great regret at having to leave the job and his clients, but he saw no future to the position.

Although it is too early to tell how much increased turnover will affect continuity and quality of care, one would readily predict that some client contact would be lost. Since rapport is often what the outreach worker must strive the hardest to obtain, it seems unlikely that a new outreach worker could step in without spending a great deal of effort to regain that rapport.

The 5150 Process

The HMD program is a voluntary program, but outreach workers are faced with deciding whether an individual is really a threat to himself or others. If the answer is yes, then the worker must consider whether a brief stay in an inpatient setting will be helpful. The consensus among the outreach workers was that the process neither guaranteed that the individual would be retained for any length of time, nor guaranteed follow up after discharge. A respondent for the West Sacramento police also expressed dismay that the time to do the paperwork was usually longer than the individual's length of stay as an inpatient.
Underserved Populations

Currently women in Yolo County do not have the same access to shelter as men. This will be remedied when the Wayfarer Mission opens its women’s shelter, which it plans to do soon. However, families remain a problem: men must be separated from women and children.

Although it is believed that the county is doing relatively well for the 20 to 40 year olds, some respondents indicated that other age groups (e.g., adolescents, young adults, the elderly) are not adequately served. The dual diagnosed client who is actively using drugs or alcohol was identified as another population that the HMD program could not adequately serve. The Asian-Pacific minority group was also identified as having trouble accessing the services of the HMD program.
LOS ANGELES COUNTY: SKID ROW

This case study differs from the other three in that it focuses on a single geographic area within a county rather than examining the entire county. However, to set the context for the programmatic discussion, we will provide some data on Los Angeles County as a whole and indicate how Skid Row differs. The decision to focus on Skid Row was made because we have data on the HMD population in that area from another study.\(^1\) Also, given the size of Los Angeles County, focusing on a single service area provided a more manageable approach to understanding the programmatic issues faced in the county.

COUNTY CONTEXT
Demographic Profile

Los Angeles County is an urban county, located in the southern portion of the state, and is the most populous county. The three largest cities are: Los Angeles, Long Beach, and Glendale, as shown in Table I.22. Incomes in Los Angeles County are at about the state average, with per capita incomes being slightly higher and median family income being somewhat lower. These averages, however, mask the extent of poverty in the county regarding the proportions of the population living below the poverty line; in all categories, the proportions exceed the state average, most dramatically for children. The minority population is above the state average, but is substantially lower than that in Alameda County.

Table I.22

LOS ANGELES COUNTY: SELECTED CHARACTERISTICS

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (1/1/86)</td>
<td>8,155,300</td>
</tr>
<tr>
<td>Three largest cities</td>
<td></td>
</tr>
<tr>
<td>Los Angeles</td>
<td>3,215,500</td>
</tr>
<tr>
<td>Long Beach</td>
<td>392,300</td>
</tr>
<tr>
<td>Glendale</td>
<td>152,500</td>
</tr>
<tr>
<td>Racial composition</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>68%</td>
</tr>
<tr>
<td>Black</td>
<td>13%</td>
</tr>
<tr>
<td>Other</td>
<td>19%</td>
</tr>
<tr>
<td>Median age</td>
<td>29.8</td>
</tr>
<tr>
<td>Per capita income</td>
<td>$12,544</td>
</tr>
<tr>
<td>(State average: $11,968)</td>
<td></td>
</tr>
<tr>
<td>Median family income</td>
<td>$21,125</td>
</tr>
<tr>
<td>(State average: $21,537)</td>
<td></td>
</tr>
<tr>
<td>Income below poverty line</td>
<td></td>
</tr>
<tr>
<td>Individuals</td>
<td>13.4%</td>
</tr>
<tr>
<td>(State average: 11.4%)</td>
<td></td>
</tr>
<tr>
<td>Under age 18</td>
<td>21.8%</td>
</tr>
<tr>
<td>(State average: 15.2%)</td>
<td></td>
</tr>
<tr>
<td>Families</td>
<td>10.5%</td>
</tr>
<tr>
<td>(State average: 8.7%)</td>
<td></td>
</tr>
<tr>
<td>Unemployment rate (1986)</td>
<td>5.9%</td>
</tr>
<tr>
<td>(State average: 6.2%)</td>
<td></td>
</tr>
<tr>
<td>Medi-Cal recipients</td>
<td>11%</td>
</tr>
<tr>
<td>(State average: 11%)</td>
<td></td>
</tr>
<tr>
<td>SSI recipients</td>
<td>3%</td>
</tr>
<tr>
<td>(State average: 2.9%)</td>
<td></td>
</tr>
</tbody>
</table>

SOURCES: County Association of California, County Fact Book, 1987; U.S. Census, 1980.
Department of Mental Health Short-Doyle Budget

As shown in Table I.23, the FY 1986-87 mental health budget for Los Angeles County was $215,789,766 and the largest category of expenditure was for 24-hour services (58.8 percent). The second largest category was for outpatient services (17.9 percent), followed by continuing care, day services, outreach services, and administrative expenses. While all of the counties we examined spent the largest portion of their budget on 24-hour services, the expenditures in Los Angeles County are proportionately the largest and dominate the budget.

The county's allocation for the operation of its HMD program is $7,467,350 which is about 3.5 percent of the county's Short-Doyle budget and represents 37 percent of the total state HMD allocation. When the HMD program began, the administration of the Los Angeles County Department of Mental Health was decentralized across five service regions. Accordingly, the budget for this new program was distributed across the regions based on an index of five factors believed associated with the proportion of homeless mentally ill in each area. The five factors were: (1) General Relief recipients; (2) other welfare

Table I.23

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative</td>
<td>$9,687,895</td>
<td>4.5</td>
</tr>
<tr>
<td>Outreach services</td>
<td>14,949,971</td>
<td>6.9</td>
</tr>
<tr>
<td>24-hour services</td>
<td>126,895,965</td>
<td>58.8</td>
</tr>
<tr>
<td>Day services</td>
<td>10,062,892</td>
<td>4.7</td>
</tr>
<tr>
<td>Outpatient services</td>
<td>38,568,918</td>
<td>17.9</td>
</tr>
<tr>
<td>Continuing care</td>
<td>15,624,125</td>
<td>7.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$215,789,766</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

recipients; (3) minority populations; (4) chronically mentally ill patients; and (5) community care beds. This index is different from the one employed by the state to allocate the HMD program funds to the counties. Based on the L.A. Index, the central region, which contains Skid Row, received an allocation of 33.5 percent of the funds, or $2,111,184; this was the largest allocation received by any region. The central region was the "neediest" along all five dimensions.

Los Angeles County Homeless Population

The original application to the state for HMD funding contained no estimate of the number of homeless or homeless mentally disabled individuals in L.A. County. The proposal asserted that Los Angeles had half of the homeless population in the state (although the baseline number was not indicated) and that the 37 percent allocation from the HMD program would be inadequate to meet the need. The Homeless Coordinator indicated that at the time of the application for HMD funding the estimated homeless population was about 30,000-35,000 individuals, about 25-33 percent of whom were considered seriously mentally ill (7,500-11,550 individuals). She indicated, however, that the population continues to increase and may soon be as high as 50,000.

Pre-HMD Program Activities

Below we discuss programs in Skid Row that existed prior to implementation of the HMD program; other activities in L.A. County related to serving the HMD are not included.

In 1981, the Skid Row Mental Health program was added to the county mental health system. This clinic was designed to serve the homeless mentally disabled. The program began with outreach and consultation services being operated out of the central office. In 1982, a full-time psychologist was hired and crisis intervention services were added.

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2 The state used the following factors to allocate HMD funds: (1) population in households with an income at or below 125 percent of the poverty level; (2) number of disabled SSI/SSP (State Supplementary Payment) recipients (excludes elderly and blind); (3) number of General Relief recipients; (4) unemployment rate; and (5) population.
to the outreach and consultation functions. The program was moved from
the central office to clinic operations. Additional funding was
obtained from the JOBS bill (although this had to be spent within six
weeks). In the summer of 1983, the program moved into a couple of
offices in its current location in the Weingart Center Association
building. In 1985, the clinic received an augmentation from the
Short-Doyle program and had an operating budget of $700,000. By this
time, the clinic was fully operational; it represents the central focus
of the HMD program in Skid Row today. While there were other shelters
and food programs operating in Skid Row, none catered exclusively to the
HMD and many may have excluded this population because of the tendency
toward disruptive behavior.

IMPLEMENTATION OF THE HMD PROGRAM

Below we describe the implementation of the HMD program in Skid Row
with some details about overall implementation in Los Angeles County, as
necessary to set the context for Skid Row.

Overview of the HMD Program

The Director of Mental Health for Los Angeles County indicated that
the goal of the program was to establish ongoing contact with the
chronically mentally ill homeless and those who are at risk for becoming
homeless. The HMD program offered a flexible means of accomplishing
this goal, particularly with respect to engaging clients. The Los
Angelas County program gave priority to the currently homeless.

Initially, program funding decisions were made by each of the
mental health regions in the county. Programs received funding in two
different categories: (1) augmentation and (2) rollover. The
augmentation category reflected the intention to continue funding the
activity of a particular program whereas the rollover category reflected
a one-year commitment to funding a particular activity. In FY 1986-87,
rollover funds totaled $4-5 million; by FY 1987-88, they totaled about
$1 million. Programs receiving rollover funds were told that the money
was a one-time only grant and that subsequent funding would have to be
obtained from other sources. As the rollover amounts have declined, the
county has had to make decisions about which programs to continue supporting. Priorities were established by a panel that rated each of the programs being funded, and the county funded the programs in priority order until the rollover amounts were exhausted. Only one program in Skid Row that received rollover funding is no longer receiving HMD funds.

The Skid Row HMD programs are centered around the Skid Row Mental Health Clinic, which is operated and staffed by the county. The clinic provides a wide range of services including outreach, case management, outpatient treatment, socialization, money management, mobile psychiatric team, and referrals to shelter. The clinic's mission is to serve the homeless mentally disabled, thus the HMD-funded activities are integrated into other clinic operations.

L.A. Mens Place (LAMP) is a key agency operating in Skid Row. It was opened in June of 1985 and provides drop-in, shelter, money management, and transitional residential services. The agency works closely with the Skid Row Mental Health Clinic. LAMP has received HMD funds for the shelter operation and was supposed to be receiving funds for outreach, but had not yet received the money by the time of our visit in December of 1987.

A third agency operating in Skid Row with HMD funds is Travelers Aid. The agency provides information and referral and outreach services; Travelers Aid also serves as the administrative agency for the county's FEMA voucher program. The outreach services provided by Travelers Aid are conducted in conjunction with the team from the Skid Row Mental Health Clinic.

The other two agencies continuing to receive HMD funding provide special mental health shelter beds: Weingart Center Association (6 beds) and Transition House (20 beds). Together with the LAMP beds (18), Skid Row has 16 percent of the beds funded through the HMD program.

A variety of other agencies operate in Skid Row, primarily providing shelter, housing, food, and drop-in services. These agencies receive funding from various sources including federal and city governments, the Community Redevelopment Agency, and private donations.
Allocation of HMD Funds

The central region in L.A. County, in which Skid Row is located, received the largest proportion of HMD funding—about 33 percent of the total. Table I.24 lists the contractors and county agencies that are being supported by HMD funds in FY 1987-88.

Organization and Management

Programmatic responsibility for the HMD program in Los Angeles County is with the Homeless Coordinating Unit. The director of that unit reports to the Director of Community Programs who reports to the Director of Mental Health for L.A. County. The Homeless Coordinating Unit monitors all aspects of HMD-funded program operations. This involves providing technical assistance, monitoring program activities,

Table I.24

HMD-FUNDED AGENCIES AND SERVICES IN SKID ROW

<table>
<thead>
<tr>
<th>Agency</th>
<th>Amount</th>
<th>HMD-Funded Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skid Row Mental Health</td>
<td>$853,178</td>
<td>Mental health, money management, outreach, socialization center, case management</td>
</tr>
<tr>
<td>LAMP</td>
<td>38,000</td>
<td>Drop-in/outreach</td>
</tr>
<tr>
<td></td>
<td>55,480(a)</td>
<td>Specialized shelter</td>
</tr>
<tr>
<td>Travelers Aid</td>
<td>25,000</td>
<td>Outreach</td>
</tr>
<tr>
<td>Transition House</td>
<td>138,700(a)</td>
<td>Specialized shelter</td>
</tr>
<tr>
<td>Weingart Center Association</td>
<td>41,610(a)</td>
<td>Specialized shelter</td>
</tr>
</tbody>
</table>

SOURCE: Homeless Coordinating Unit, personal communication.
(a) Actual amounts received are based on utilization. These figures represent maximum amounts and are based on the number of beds available times the reimbursement rate ($19 per day) times 365 days.
evaluating programs, training staff, planning and developing programs, fund raising, conducting regular meetings of contractors, providing a central focus for homeless programmatic efforts, and being an advocate for the target population. The unit has 6 full-time staff. The unit also operates the Cold Weather Emergency Shelter program.

Programs funded under the HMD allocation are monitored twice a year and visited at least once. Two staff members conduct the monitoring visit using a standard protocol. After the visit is conducted, the county sits down with representatives of the program and of other programs that work with the agency being reviewed; they discuss problems and results of the visit and develop plans for action.

The Homeless Coordinating Unit also began publishing a newsletter in the spring and summer of 1987 containing articles about some of the contractors providing services under the HMD program, a calendar of relevant events in each of the service areas, and other county information of general interest to providers. The Homeless Coordinator believes that the newsletter fulfills an educational purpose by using stories about programs to illustrate how to approach serving the target population.

PERSONS SERVED

We were able to obtain a tape from the Los Angeles County Management Information System (MIS), which allowed for a comparison between the individuals served through agencies funded by the HMD allocation and other mental health programs in the county. We present some of those comparisons below. First, however, we present data from the state's quarterly report indicating the overall level of program activity. Again, it is important to remember that these are data for the whole county, not just Skid Row.
Overall Program Activities

As indicated in Table 1.25, for most categories of activities there was a substantial increase between December of 1986 and March of 1987 and then a leveling off by June of 1987. This was probably the result of both program start-up and weather. The programs were just being implemented in December of 1986; by March many programs might have reached their peak. As the weather improved, demand for services such as shelter may have declined. Longer-term services such as mental health day services, mental health outpatient, case management, and board and care placement continued to grow. Some of these services may represent clients who had been in the system a longer time and who gradually accepted services beyond basic subsistence.

Client Characteristics

While the data required some interpretation to make comparisons, we examined the characteristics of homeless clients receiving HMD-funded services with "at-risk" clients who received services in the rest of the county mental health system. As shown in Table I.26, the distribution of client characteristics between homeless and "at-risk" clients receiving HMD-funded services is similar. However, the at risk have: a higher proportion of women; almost three times as many Hispanics; more individuals under the age of 25; and more than twice as many married and somewhat more married at one time. The homeless have somewhat more blacks. Data obtained from the Skid Row Mental Health Clinic indicated that the population served there has an even higher proportion of males (73 percent) than is true for L.A. County as a whole.

For this analysis, the "homeless" were defined as those who were listed as transients or who had no data in the address column. Those with valid addresses were considered "at risk" of becoming homeless. There were some difficulties with using the data in this way because of the possible error in assigning individuals to categories. Thus, these figures should be used as general indicators rather than as absolute comparisons.
Table I.25

LOS ANGELES COUNTY OVERALL HMD PROGRAM ACTIVITIES

<table>
<thead>
<tr>
<th>Activity</th>
<th>December 1986</th>
<th>March 1987</th>
<th>June 1987</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unduplicated clients</td>
<td>1,253</td>
<td>3,079</td>
<td>2,699</td>
</tr>
<tr>
<td>Average # beds used</td>
<td>58</td>
<td>171</td>
<td>182</td>
</tr>
<tr>
<td>Average # meals served</td>
<td>338</td>
<td>647</td>
<td>693</td>
</tr>
<tr>
<td>Assessments</td>
<td>125</td>
<td>1,031</td>
<td>769</td>
</tr>
<tr>
<td>Referrals</td>
<td>422</td>
<td>971</td>
<td>753</td>
</tr>
<tr>
<td>Shelter</td>
<td>162</td>
<td>677</td>
<td>334</td>
</tr>
<tr>
<td>Food</td>
<td>1,561</td>
<td>2,252</td>
<td>1,927</td>
</tr>
<tr>
<td>Clothing</td>
<td>336</td>
<td>612</td>
<td>535</td>
</tr>
<tr>
<td>Financial support</td>
<td>13</td>
<td>111</td>
<td>88</td>
</tr>
<tr>
<td>Money management</td>
<td>83</td>
<td>173</td>
<td>320</td>
</tr>
<tr>
<td>Psychotropic medication</td>
<td>544</td>
<td>672</td>
<td>622</td>
</tr>
<tr>
<td>Mental health day services</td>
<td>425</td>
<td>606</td>
<td>866</td>
</tr>
<tr>
<td>Mental health outpatient</td>
<td>191</td>
<td>222</td>
<td>256</td>
</tr>
<tr>
<td>Mental health 24-hour care</td>
<td>41</td>
<td>222</td>
<td>153</td>
</tr>
<tr>
<td>Case management</td>
<td>382</td>
<td>1,097</td>
<td>1,165</td>
</tr>
<tr>
<td>Involuntary hospitalization</td>
<td>12</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>Transportation</td>
<td>257</td>
<td>429</td>
<td>448</td>
</tr>
<tr>
<td>Board and care placement</td>
<td>27</td>
<td>55</td>
<td>77</td>
</tr>
</tbody>
</table>

SOURCE: County reports to the State Department of Mental Health.

NOTE: Figures represent the cumulative level of activities over a one-week period during the month indicated.

In Table I.27 we look at the client characteristics of individuals who received services in the rest of the county mental health system. Again, the comparison we made was between homeless and "at-risk" clients. There are greater differences between the homeless and "at-risk" clients who received services in the regular mental health system than between the homeless and "at-risk" clients who received services through HMD-funded programs. The "at risk" were almost equally divided between men and women whereas the homeless were more dominantly male; there were fewer whites and more Hispanics in the "at-risk" population; almost twice as many in the "at-risk" population under the age of 25 and considerably fewer were in the 25-44 age range; more than twice as many
of the "at-risk" clients were married, but again the dominant characteristic is for clients to have never been married.

The other comparison we made was by diagnostic category and is shown in Table I.28. Schizophrenia was the most common mental disorder for both the homeless and the "at-risk" clients receiving services in HMD-funded programs. Major affective disorder (major depression and

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>Homeless (Percent)</th>
<th>&quot;At Risk&quot; (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>68.7</td>
<td>62.9</td>
</tr>
<tr>
<td>Female</td>
<td>31.3</td>
<td>37.1</td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>53.8</td>
<td>52.2</td>
</tr>
<tr>
<td>Black</td>
<td>33.9</td>
<td>30.0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>4.4</td>
<td>11.7</td>
</tr>
<tr>
<td>Other</td>
<td>7.9</td>
<td>6.1</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 25</td>
<td>7.6</td>
<td>11.3</td>
</tr>
<tr>
<td>25-34</td>
<td>36.4</td>
<td>39.9</td>
</tr>
<tr>
<td>35-44</td>
<td>27.8</td>
<td>27.6</td>
</tr>
<tr>
<td>45-54</td>
<td>15.8</td>
<td>12.9</td>
</tr>
<tr>
<td>55-64</td>
<td>9.5</td>
<td>6.0</td>
</tr>
<tr>
<td>65+ years</td>
<td>2.8</td>
<td>2.3</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>3.5</td>
<td>7.4</td>
</tr>
<tr>
<td>Formerly married</td>
<td>20.9</td>
<td>23.3</td>
</tr>
<tr>
<td>Never married</td>
<td>65.2</td>
<td>57.3</td>
</tr>
<tr>
<td>Unknown</td>
<td>10.4</td>
<td>12.0</td>
</tr>
</tbody>
</table>

SOURCE: Los Angeles County Management Information System, 1987 data.
bipolar disorder) was relatively more frequent among the "at-risk" clients. Although other categories showed some small differences, in general, the profiles were similar. At the Skid Row Mental Health Clinic, 56 percent of clients seen had schizophrenia; 7.8 percent had major bipolar disorder; 6 percent had major depression; and 5.6 percent had another psychotic disorder.

Table I.27

COMPARISON OF DEMOGRAPHIC CHARACTERISTICS:
HOMELESS VERSUS AT-RISK CLIENTS RECEIVING OTHER MENTAL HEALTH SERVICES

<table>
<thead>
<tr>
<th>Demographic Characteristic</th>
<th>Homeless (Percent)</th>
<th>&quot;At Risk&quot; (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>35.1</td>
<td>49.2</td>
</tr>
<tr>
<td>Male</td>
<td>64.9</td>
<td>50.8</td>
</tr>
<tr>
<td>Race/ethnicity</td>
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<td></td>
</tr>
<tr>
<td>White</td>
<td>51.5</td>
<td>43.6</td>
</tr>
<tr>
<td>Black</td>
<td>25.0</td>
<td>23.9</td>
</tr>
<tr>
<td>Hispanic</td>
<td>17.3</td>
<td>25.1</td>
</tr>
<tr>
<td>Other</td>
<td>6.2</td>
<td>7.4</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 25</td>
<td>14.8</td>
<td>29.7</td>
</tr>
<tr>
<td>25-34</td>
<td>35.2</td>
<td>25.3</td>
</tr>
<tr>
<td>35-44</td>
<td>26.4</td>
<td>20.1</td>
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<tr>
<td>45-54</td>
<td>10.6</td>
<td>12.1</td>
</tr>
<tr>
<td>55-64</td>
<td>7.7</td>
<td>8.1</td>
</tr>
<tr>
<td>65+ years</td>
<td>5.3</td>
<td>4.8</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>6.1</td>
<td>13.2</td>
</tr>
<tr>
<td>Formerly married</td>
<td>14.3</td>
<td>20.9</td>
</tr>
<tr>
<td>Never married</td>
<td>58.5</td>
<td>55.0</td>
</tr>
</tbody>
</table>

SOURCE: Los Angeles County, Management Information System, 1987 data.

The profile of diagnoses for clients in other mental health programs was somewhat different, as shown in Table I.29. Schizophrenia was less common among the homeless in other programs, although still
substantial; among the "at risk" in other programs, schizophrenia occurred about half as often as among both the homeless and "at risk" in HMD-funded programs. Major affective disorder (major depression and bipolar disorder) was more common among the "at risk" than the homeless. Adjustment disorder was found more than twice as often among the "at risk" than the homeless. Substance use disorders were found almost three times more among the homeless than the "at risk". It appeared from this data that the HMD-funded programs were serving a somewhat different clientele diagnostically than the other mental health programs.

Table I.28

COMPARISON OF DIAGNOSTIC CHARACTERISTICS: HOMELESS VERSUS AT-RISK CLIENTS RECEIVING HMD-FUNDED SERVICES

<table>
<thead>
<tr>
<th>Diagnostic Characteristics</th>
<th>Homeless (Percent)</th>
<th>&quot;At Risk&quot; (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>41.4</td>
<td>41.1</td>
</tr>
<tr>
<td>Major depression</td>
<td>9.2</td>
<td>13.3</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>7.6</td>
<td>10.3</td>
</tr>
<tr>
<td>Substance disorders</td>
<td>5.3</td>
<td>4.0</td>
</tr>
<tr>
<td>Childhood disorders</td>
<td>0.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>1.3</td>
<td>2.1</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>0.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>6.6</td>
<td>5.4</td>
</tr>
<tr>
<td>Psychosexual disorder</td>
<td>0.3</td>
<td>0.1</td>
</tr>
<tr>
<td>Organic brain syndrome</td>
<td>2.5</td>
<td>1.3</td>
</tr>
<tr>
<td>Other/not defined</td>
<td>24.3</td>
<td>20.4</td>
</tr>
</tbody>
</table>

Total 100.0 100.0

SOURCE: Los Angeles County, Management Information System, 1987 data.
Table I.29

COMPARISON OF DIAGNOSTIC CHARACTERISTICS:
HOMELESS VERSUS AT-RISK CLIENTS RECEIVING
OTHER MENTAL SERVICES

<table>
<thead>
<tr>
<th>Diagnostic Characteristics</th>
<th>Homeless (Percent)</th>
<th>&quot;At Risk&quot; (Percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>31.9</td>
<td>22.2</td>
</tr>
<tr>
<td>Major depression</td>
<td>5.4</td>
<td>10.0</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>5.8</td>
<td>6.6</td>
</tr>
<tr>
<td>Substance disorders</td>
<td>9.0</td>
<td>3.5</td>
</tr>
<tr>
<td>Childhood disorders</td>
<td>1.1</td>
<td>7.6</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>0.5</td>
<td>4.9</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>1.2</td>
<td>1.3</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>6.8</td>
<td>16.5</td>
</tr>
<tr>
<td>Psychosocial disorder</td>
<td>1.2</td>
<td>0.3</td>
</tr>
<tr>
<td>Organic brain syndrome</td>
<td>4.6</td>
<td>1.4</td>
</tr>
<tr>
<td>Other/not defined</td>
<td>32.6</td>
<td>25.4</td>
</tr>
</tbody>
</table>

SOURCE: Los Angeles County, Management Information System, 1987 data.

PROGRAM ACTIVITIES

Below we discuss some of the programs serving the HMD that are of particular interest to the state and legislature: outreach, intake and screening, case management, drop-in centers, financial assistance, mobile crisis, shelters, county mental health, and residential housing and treatment. We will focus on the programs in Skid Row that are being funded through the HMD allocation.

Outreach

The Skid Row Mental Health Clinic has three outreach teams, each of which conduct active street outreach one-half day per week in the morning. Responsibility for conducting outreach (and most of the other outpatient clinic-related activities) rotates across all of the staff. They drive around Skid Row in county cars looking for clients who might need their services. Concerns about safety dictated the time of day during which outreach was conducted, dictated the team approach, and
restricted the areas in which they conducted outreach. The teams targeted their efforts on the most severely mentally disabled—those who might not seek services on their own. About 10-20 percent of the contacts made through street outreach are with new clients. The remainder of contacts are with individuals who have not recently been into the clinic or with individuals who have not yet accepted shelter, drop-in, or mental health services. The outreach workers estimate that about 5-10 percent can never be engaged through outreach efforts, primarily because of substance abuse problems.

In a typical outreach encounter, the team does a brief informal screening to determine whether the individual is homeless and uses behavioral indicators to gauge whether the person is likely to have a mental illness. Everyone who is approached receives a packet of food. Efforts are made to link people with LAMP, SSI, and the Volunteers of America Detoxification, Screening and Referral Service (VOA) (located in the Weingart Center building) for detoxification if necessary. Those who are engaged are encouraged to go to the Skid Row Mental Health Clinic for follow-up. Approximately 50-60 percent of those engaged come to the clinic and have a case opened. Cases are only opened for those with major mental disorders; many of these individuals are likely to be eligible for SSI.

Travelers Aid also has a counselor who joins the Skid Row Mental Health Clinic team once or twice a week.

The Skid Row Mental Health Clinic also relies on agency-to-agency outreach, particularly with Department of Public Social Services (DPSS). The clinic has a special arrangement with DPSS to process mental health clients. The staff at DPSS is good at identifying and referring mentally ill clients to the Skid Row Mental Health Clinic. The clinic staff has worked closely with DPSS staff to build these skills.

Intake and Screening

The Skid Row Mental Health Clinic has the most extensive intake and screening procedures of the agencies operating in the Skid Row area. It is able to make formal diagnoses and set up written service plans. Clients coming in for services at the clinic will have both a medical
record and a case management record opened on them. Both of these forms are linked into MIS.

Travelers Aid conducts intake and screening activities somewhat less formally because they are not primarily a mental health treatment agency. It is primarily designed to link individuals with housing and transportation services. Travelers Aid is linked into the MIS and reports data as required by that system. Written service plans focus on meeting the basic needs of individuals. The counselors at Travelers Aid do a brief screening for mental illness based on a history and on behavioral indicators. In addition they obtain information about the individual’s housing situation and problems with drugs and/or alcohol.

LAMP, because it operates primarily as a drop-in center, does not conduct formal intake and screening activities. However, the mission of the agency is to serve homeless mentally disabled men, and those who do not fit that characterization tend not to use the agency services. As an individual becomes more comfortable with the staff and program at LAMP, staff may obtain information about an individual’s history of treatment for mental illness; staff also will try to link an individual with other services he has expressed an interest in.

Case Management

All three agencies do some form of case management, although the content of the activity varies by agency. The Skid Row Mental Health Clinic has a formal case management program. It is organized around a team, which means that clients will be seen when they come in but not necessarily by the same counselor. These are the same teams that rotate outreach responsibilities. The team approach is designed to respond to the utilization patterns of the HMD in Skid Row—appointments are not a reliable way of keeping in touch with people, so when an individual arrives asking for some service, the team attempts to take care of any outstanding problems being experienced by the individual. Maintaining a formal case management chart assists the team in serving the individual because reference can be made to what occurred previously and what remains to be addressed. The team takes a problem-solving approach and is willing to do whatever needs to be done (e.g., it has even cleaned
rooms in Single Room Occupancy (SRO) hotels to keep clients from being evicted).

Case management at Travelers Aid is a short-term activity focused on linking individuals with services, primarily food, housing, and transportation. Cases typically stay open about one to two months.

LAMP works with clients to obtain the services desired by the individual. They try to encourage individuals to apply for benefits, obtain housing, and eventually link up with the Skid Row Mental Health Clinic. Often, obtaining benefits requires cooperation between staff at LAMP and the clinic.

The major source of referral for the three agencies in Skid Row is self-referral or word-of-mouth. LAMP receives all of its clients this way. Travelers Aid reports that about 60 percent of clients are self-referred and another 15 percent have used Travelers Aid services previously; about half of the Skid Row Mental Health Clinic clients refer themselves. The second most common source of referral is from other agencies. The clinic receives a majority of the remaining 50 percent of its referrals from LAMP. About 20 percent of Travelers Aid referrals come from other Skid Row agencies.

Both the clinic and LAMP refer all of the clients that remain with them for any period of time to SSI. These agencies serve a clientele that is predominantly eligible for SSI. LAMP refers about 80 percent of its longer term clients to the clinic for some of the services offered there. Most of the Travelers Aid referrals are for food or shelter services.

Drop-In Centers

LAMP is the major drop-in center operating in Skid Row that serves the mentally ill. The drop-in center is open seven days per week from 8:00 a.m. to 5:00 p.m. and is located in an on-street building. LAMP serves breakfast, lunch, and a snack; and provides clothing, showers, laundry, toiletries, towels, limited kitchen access, TV, a mailbox, representative payee and money management services. The center has a number of activities, most of which are focused on individuals, but there are some group activities including a living skills workshop.
LAMP has about 200 regular clients and sees about 80 individuals on any given day.

The Skid Row Mental Health Clinic operates a socialization program six days per week (Monday through Saturday) from 8:00 a.m. to 3:00 p.m. on the second floor of the clinic building. One of the staff was supported from HMD rollover funds. The socialization program serves a breakfast, conducts some social skills training classes, and has other socialization activities targeted at individuals (e.g., games, cards, painting). The program serves between 18 and 30 clients each day.

Financial Assistance

The Skid Row Mental Health Clinic runs a money management program that serves about 95 clients. One of the administrators we spoke with indicated that this program has had a more dramatic impact than any other. In part this is because the clinic is able to maintain longer-term contact with clients for whom it is managing funds. Staff are also aware of the mail being received from SSI and can work with the client to respond to recertification and other requests. This enables the client to maintain benefits more consistently. The administrator indicated that having money management located together with mental health services was the most effective combination.

LAMP serves as a representative payee for 30 clients and manages money for an additional 15. The director indicated that financial management was a fundamental service need for the HMD. She suggested that among the side benefits of the money management program was the capability to "control" an individual's drug habit by limiting daily access to funds. LAMP has been taking this unusual approach to the problem of clients spending all of their resources on drugs: They treat it as a budget management issue. They have found clients more receptive to this approach.
Mobile Crisis

The Skid Row Mental Health Clinic has a mobile psychiatric team that responds to crisis calls primarily from the community, especially families. The mobile crisis program operates 7 days a week, 24-hours a day. The program serves the entire geographic area service region 8. Up to six staff members are available; a minimum of two are on call at any time. The program has recently come under the clinic's management and this has improved the clinic's ability to respond to the range of needs of the HMD.

Shelters

The HMD program provides vouchers for shelter that reimburse operators at a daily rate equivalent to that for board and care homes ($19 per day). To obtain a voucher, a client must be certified by the closest county mental health clinic as being eligible for the program (homeless and severely mentally ill).

The shelter program at LAMP opened in March of 1987. There are 18 beds and currently no length-of-stay limits. Approximately 8 beds are used on an average night. The presence of the shelter has helped in building the trust of LAMP clients. The other HMD-funded shelter beds are located in the Weingart Center building (6 beds) and at Transition House (20 beds). Length of stay is limited to 75 days. A liaison from mental health goes to the shelters to work with clients.

A number of other shelters operate in Skid Row that do not receive HMD funds (Union Rescue Mission, St. Julian's, Salvation Army, Los Angeles Mission, Fred Jordan Mission). According to one report, over 1,000 beds and almost 5,000 meals are available from these agencies each day.4

County Mental Health

The Skid Row Mental Health Clinic has a central role in the provision of services to the HMD in Skid Row. Unlike other county mental health clinics in Los Angeles, this clinic's exclusive target population is the homeless mentally disabled.

It is important to note that the county department of mental health was concerned about the population on Skid Row long before the HMD legislation was enacted. The programs that were already operating in the Skid Row area wanted support from mental health, e.g., the clinic was designed with the needs of this population in mind. Thus, rather than trying to serve a different target population after the legislation passed, the clinic continued to serve the HMD. This is the exception rather than the rule both in Los Angeles County and in the other counties we interviewed.

Residential Housing and Treatment

There are no HMD-funded transitional residential or long term housing programs currently operating in Skid Row. LAMP has plans to open a 45-bed transitional housing and vocational training program in Skid Row designed to provide a stable living environment that supports making gains in and decisions about lifestyles. The building, at Crocker and San Pedro, would house the residence, some businesses, and public showers and bathrooms. The length of stay would be several months to a year. Currently the program is being delayed because of a protest by the Central City East Association, a group of businesses operating in Skid Row.

LAMP also has purchased a hotel in Echo Park with plans to establish semi-supervised alternative housing for the mentally disabled. The hotel would have a continuum of services available to its residents. This project is also being delayed because of community resistance.


EFFECTS OF THE HMD PROGRAM

We now discuss the effects of the HMD program on coordination of services and consider the extent to which the HMD in Skid Row are targeted, engaged, and provided services on a long-term basis. We also discuss the effects of the program on the community.

Coordination

The Homeless Coordinating Unit has been working on improving the coordination among providers in each of the service regions. Toward this end, the county has been holding regular meetings with all providers funded through the HMD program and used these forums to conduct ongoing planning and training. These meetings also allow for networking and problem identification among providers. The unit has established a "coordinating clinic" concept, using mental health clinics in each of the service regions to provide a central focus for HMD programs in the region. Among the goals of this planning effort is making the HMD a priority target population in each area.

Targeting and Engaging the HMD

In Skid Row, the programs clearly focus on the intended target population. They are serving the homeless or those living in SROs and they are serving only those with major chronic mental disorders. Few efforts in this geographic area extended to the "at-risk" population: The mobile crisis team takes calls from families experiencing crises with mentally ill relatives, and the population living in SROs receives services (they could be considered "at risk" rather than currently homeless because they have a roof over their heads).

A large portion of engagement comes through self-referral. We did not have enough information to judge who was not being served through this process. Most participants in on-street outreach agree that it is not the most efficient way of engaging individuals, however, it is likely to reach a different population than is reached through referrals from other agencies.
One respondent indicated that the county was limited in its ability to give the level of care needed for the most severely mentally ill because of the lack of acute care beds. Many of the individuals identified through outreach may require involuntary hospitalization, but the capacity does not exist to treat everyone who needs it through this mechanism.

The dual diagnosis population is particularly underserved, as we found in other counties. We were told that the dual diagnosed represent between 30 and 80 percent of the HMD in Skid Row. At the Skid Row Mental Health Clinic, one respondent indicated that substance abuse is more common in Skid Row than major mental illness. Mental health clinics will not give medication to individuals who are intoxicated or high. These individuals may also be asked to leave other programs until they are sober. Referrals are sometimes made to the VOA located in the Weingart Center building for detoxification services. LAMP will tolerate individuals as long as they are not intoxicated or obviously under the influence of other substances.

Serving the HMD

Four dimensions of the services provided to the HMD merit special attention: subsistence, entitlements, mental health services, and long term housing placements.

Subsistence. The Skid Row Mental Health Clinic provides referrals to specialized mental health shelters for about 30 people on an average night. This is the main subsistence service delivered to clients in Skid Row. Two meals a day are provided to those receiving specialized shelter services. The drop-in/socialization centers serve breakfast and one serves lunch. We will not comment here on the adequacy of services available, but it appears that subsistence services were the major type of service provided in Skid Row prior to the establishment of the clinic.

Entitlements. Both the Skid Row Mental Health Clinic and LAMP indicated that they eventually get all of their clients to apply for SSI. Clinic staff indicated that at the time of formal admission to the
outpatient clinic program, about 55 percent of clients have no source of income; of the remaining 45 percent about half are on General Relief and half are on SSI. These proportions seem high relative to our findings from the survey reported in Sec. Ill, but this may be due to the characteristics of individuals who seek services at the clinic—they are relatively more likely to have sought and received public entitlement benefits. In fact, the clinic director indicated that those encountered through street outreach generally have no source of income. Because there were already groups providing advocacy services, the county did not fund a separate advocacy program in Skid Row. Both the clinic and LAMP work with clients to obtain benefits; for those requiring more assistance, referrals are made to the Intercity Law Center. A special project with DPSS was designed to train General Relief eligibility workers to identify the mentally ill and refer them to the Skid Row Mental Health Clinic.

Mental Health Services. Between April and September of 1987, the outpatient department at Skid Row Mental Health Clinic saw an average of 1,223 clients per month. There seems to be close cooperation between the clinic and other providers in the Skid Row area, with many encouraging clients to use the mental health services offered by the clinic. Individuals can be seen on a drop-in basis which enhances access to services. The team approach is designed to ensure that an individual will be seen when he or she walks in.

Long-Term Housing Placements. We were not able to obtain data on the number of placements made into long-term housing from programs in Skid Row. Most people we spoke with indicated that there was a serious shortage of appropriate, supported long-term housing in the area. One respondent suggested that the optimal solution was to move people out of Skid Row to break the cycle. The project in Echo Park planned by LAMP represents such an effort. Board and care homes are not seen as acceptable to many of the mentally ill; many are also unwilling to use residential treatment facilities.
Effects on the Community

The community has become more aware of the plight of the HMD both through media attention and through the funding of agencies not previously serving the HMD (e.g., Jewish Family Services now runs a mobile outreach program). The director of the Homeless Coordinating Unit indicated that the public is not able to differentiate among various subpopulations of the homeless. The public is acquainted with the issues regarding the homeless who are mentally ill and while they are relatively more sympathetic to the problems faced by such individuals, they are unwilling to have programs located in their own neighborhoods. Most people living in Los Angeles County never enter Skid Row and thus the population is quite separate, however, businesses in the area have been resistant to adding new programs for the HMD.

PROPOSED CHANGES AND PRIORITIES

Below we address the proposed changes and priorities for Los Angeles County as a whole, rather than focusing strictly on the Skid Row area.

The Director of Mental Health in Los Angeles County believes that there is a critical shortage of 24-hour acute care beds for the HMD and that the HMD program should include acute care beds as an appropriate category for funding. He also indicated that there is a problem with youth (ages 15-18) who are being seen in Hollywood and in Skid Row. Treating this age group is prohibited.

Given additional resources, the county would do the following: First it would expand some of the programs that have been successful (e.g., Project Return) and make them available in all eight service areas. Second, it would increase the availability of long-term residential beds. Third, it would emphasize programs for young adults and children. Fourth, it would support a revision of the Lanterman-Petris-Short Act to enable the mental health system to provide acute care services as necessary for the HMD. Fifth, it would increase the number of case management staff assigned to both money management and case management in order to increase services and decrease case loads.
GAPS IN SERVICES
Long-Term Housing

There is a serious problem with the availability of long-term housing arrangements that are acceptable to the seriously mentally ill. Most clients are unwilling to go into board and care facilities; the SROs, which are more acceptable to clients than board and care, do not offer an appropriate living environment for many individuals. One of the program directors we interviewed indicated that there should be a continuum of acceptable and accessible housing options, varying both in the level of supervision and the rents charged. It was suggested that these housing options should be developed outside of the Skid Row area in order to move people out into more stable living environments and "break the cycle of homelessness."

Dual Diagnosis

As was true in all of the counties we studied, a serious problem exists in serving the dual diagnosed population. The Homeless Coordinating Unit has made this a major priority by sponsoring a series of lectures and training sessions co-sponsored by the Los Angeles County Homeless Coalition. The focus is on building skills and exchanging information about successful treatment approaches. Three programs in the county currently have programs that focus on the dual diagnosed client: LAMP, Portals, and Kedrin. Despite these efforts, more programs are needed.

Drop-in Centers

The Director of LAMP suggested that there was a need for more drop-in centers modeled after the program at LAMP, but serving different groups of HMD (e.g., women, young adults). Some other drop-in programs operate in Skid Row, but none of these are currently receiving HMD funding.
REFERENCES


