The McKinney Mental Health Services for the Homeless Block Grant Program: A Summary of FY 1989 Annual Reports

Prepared for the National Institute of Mental Health,
Office of Programs for the Homeless Mentally Ill

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June, 1991

CONTENTS

The authors gratefully acknowledge the editorial assistance of Dr. E. Clarke Ross of the National Association of State Mental Health Program Directors.

EXECUTIVE SUMMARY

Mr. B can usually be found in front of the train station. He stands at attention in a make-shift uniform and shouts orders at an invisible squad of soldiers. His uniform looks neat, but both he and it are filthy. His hair is matted, he has open sores on his hands and arms, and his remaining teeth are rotten. He smells terrible and has a frightening, far-away look in his eyes. Most people give Mr. B a wide berth. A few laugh, a few put money in the old shoe box at his feet.

Mr. B wasn't always a street person. In high school he was a star athlete and was actually considering scholarships from several colleges. He started withdrawing from friends and family; then one day, he locked himself in a room and began talking to people he said lived inside his head. His parents, who had great hopes for him, were dumbfounded. They could barely believe it when he was diagnosed as having schizophrenia and sent to a State mental hospital. During the next seven years, Mr. B was in and out of that institution nine times and was seen at numerous outpatient clinics at the urging of his parents. While out, however, Mr. B alienated his family and friends and frustrated all attempts to help him. He wouldn't take his medicine and used what money he could get his hands on to buy cheap wine.

With nowhere to go following his most recent discharge two years ago, Mr. B has become a street person. Social workers have tried to get him on welfare and have set up appointments with mental health workers, but he can't deal with the confusing bureaucracy at the welfare office and won't show up for medical or psychiatric appointments.

Mr. B has been arrested several times for loitering and disturbing the peace--once for standing in the park picking apart dead pigeons. When he gets picked up off the streets and taken to a hospital emergency room, the interns dismiss him as a public inebriate. A human ping-pong game begins with Mr. B being bounced back and forth between the mental health and detox centers, between shelters and the street, getting no coordinated services. Mr B may disappear for months at a time, but he always ends up back at the train station shouting to his invisible army.

Homelessness in America remains a persistent problem and viable solutions continue to elude policy makers and service providers. While controversy still surrounds the issue of how many persons are homeless at any given time, it is painfully apparent that the numbers are not declining. Very

obvious among the ranks of the homeless are persons with severe mental illness. These individuals represent approximately one-third of homeless single adults and present a complicated clinical picture with multiple service needs.

Through the passage of the Stewart B. McKinney Homeless Assistance Act of 1987 and the provisions of the Mental Health Services for the Homeless (MHSH) block grant program, the Federal government began to provide support to States to improve coordination of programs at State and local levels and to fill gaps in the mental health service system through the provision of six essential services to individuals who are homeless and mentally ill. Mr. B, as well as thousands of fellow homeless mentally ill persons, are in need of these essential services, including: outreach; community mental health services; referral for medical, psychiatric, and substance abuse services; training to service providers; case management; and supportive and supervisory services in residential settings.

This document describes the efforts of the States to meet the needs of vulnerable citizens like Mr. B who are homeless and mentally ill. The document summarizes the 1989 annual reports on the Mental Health Services for the Homeless Block Grant Programs which were submitted to the National Institute of Mental Health by the 56 States and Territories. The study was commissioned by the Office of Programs for the Homeless Mentally Ill of the National Institute of Mental Health and builds upon the summary of earlier State MHSH block grant reports prepared for NIMH by Salem (1990).

The annual reports reviewed describe the number and types of clients served, needs assessment strategies used by the States in determining local

areas of highest need, program selection criteria used by the States in allocating funds, the types of agencies receiving funding, key services required by the legislation and provided by funded programs, characteristics of services delivered, consumer involvement, monitoring and evaluation of MHSH programs conducted by the States, and notable achievements and problems.

This review of the use of the FY1989 MHSH block grant funds provides ample evidence of innovative and creative uses of federal assistance in designing and providing services to homeless persons with severe and persistent mental illness. Major findings of this report include:

- All States provided required MHSH services, but there was significant variation in scope, style, and type of sponsoring agency;
- Most States stressed aggressive outreach and intensive case management as the key services;
- All States reported coordination activities and relationships with other related programs such as Community Support Projects, NIMH homelessness research and service demonstration projects, Robert Wood Johnson Foundation projects, and the Department Of Housing and Urban Development's Comprehensive Housing Assistance Plan;
- Many States recognized the importance of involving consumers and family members, along with professionals, in service provision to homeless mentally ill people.

In summary, McKinney MHSH block grant funding enabled States to develop new services and expand existing services to previously unserved or underserved areas and persons who were homeless and mentally ill. It also allowed States to improve coordination of services at both the client and service system levels. States that conducted formal evaluations were able to document considerable success in the areas of increased housing stability, decreased hospitalization rates, better use of crisis services and integration of clients into the permanent mental health service system.

The targeted McKinney resources that were provided to the States through the MHSH block grant program have been important in several ways:

- o They have focused awareness on the population of persons who are homeless and mentally ill and have provided a template, based on NIMH research findings, for the services needed;
- o The legislation has encouraged States to assume responsibility for working with localities to fill gaps in the existing service system;
- o The requirement of a match has helped States to leverage State and local funds to assist this population;
- o As more and more State economies constrict, the importance of this federal assistance has assumed even greater importance.

The reauthorization of the McKinney legislation and the new Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program (that replaces and builds upon the MHSH block grant program) reflect the continuing concern and commitment of Congress and the federal government to assist the States in meeting the multiple needs of citizens who are homeless and mentally ill.

I. Background

The issue of homelessness in America has proven to be a persistent problem and viable solutions continue to elude policy makers and service providers. Estimates of the number of persons who are homeless vary considerably. Today, government agencies and advocacy agencies commonly employ the figures of 500,000 to 600,000 persons, estimated as a result of a seven day survey in March of 1987 by the Urban Institute (1989). While controversy still surrounds the issue of how many persons are homeless at any given time, it is painfully obvious that the numbers are not declining. In fact, many sources believe that the numbers continue to rise.

Numerous factors are considered to be precipitants of homelessness. A Government Accounting Office report (1985 p. ii) suggests the following: unemployment, deinstitutionalization of psychiatric patients, increases in personal crises, cuts in public assistance, the decline in the availability of low income housing, and alcohol and drug abuse. The economic recession, coupled with increasing unemployment rates and decreasing State-level resources are causing continued concern among public officials and service providers.

Given these multiple causes of homelessness, it should not be surprising that the population of persons without stable housing represents a diverse group with equally diverse needs. Levine (1983, p.1) notes: "The homeless are a heterogeneous population comprised of many subgroups including runaway children, immigrants, migrants, so-called bag ladies, displaced families, a certain number of the unemployed, battered women, minorities, the elderly, and an overrepresentation of persons with serious alcohol, drug abuse, and mental health disorders."

The precise number and proportion of the homeless population who have serious and persistent mental illness is still a matter of some debate. As Robertson (1986) notes, the empirical research in this area does not provide consistent and reliable estimates across studies. Methodological problems including inconsistent definitions of psychiatric morbidity, differences in sampling frames, and different case-finding methods make generalizations difficult. However, there appears to be a consensus that approximately one-third of single adult homeless persons have severe and persistent mental illness (Tessler and Dennis, 1989).

In some respects, persons who are homeless and mentally ill are similar to the larger homeless population. Tessler and Dennis (1989), in a review of NIMH funded studies concluded that this subgroup mirrored the larger group with respect to age, gender, ethnicity and extent of substance abuse. However, the chronic nature of the disabilities affecting those individuals who are both homeless and mentally ill is apparent in their lower educational level, poor employment histories, truncated social networks, low marital rate, and higher rate of arrest and incarceration (Fisher and Breakey, 1986; Tessler and Dennis, 1989; Fisher, 1989).

Policy makers and service providers alike have been challenged as they attempt to meet the myriad needs of this population. It is clear that people who are homeless and mentally ill require assistance in numerous areas including basic subsistence (food, clothing and shelter); treatment of mental health, substance abuse, and physical health problems; and access to income supports. Characterizing homeless mentally ill clients served through a series of NIMH funded Community Support Program Demonstration Programs in

1986 through 1987, Hopper, Mauch, and Morse (1989, p. 19) note: "...homeless mentally ill persons are often the most disturbed and most difficult to serve clients within the mental health field. The reasons derive from the difficulty of trying to serve individuals whose needs and circumstances, including a stance of mistrust adapted as a central strategy of survival, badly frayed if not altogether absent social ties, a plethora of basic human service needs, and a high frequency of multiple disorders (i.e. alcohol and drugs, and physical as well as psychiatric problems), pose serious challenges to a service system that is both inadequate in resources and often insensitive to the special problems of the homeless."

The NIMH, as well as other agencies of the federal government and State mental health authorities have sponsored numerous research and demonstration projects to evaluate service delivery strategies designed to meet the service needs of homeless mentally ill individuals. While there is, to date, no single simple solution, there is an emerging consensus concerning the attributes of services that are more successful. First, it is clear that the needs of this population transcend the traditional boundaries of mental health systems. Most of these individuals are responsive to offers of assistance, however, their view of their own service needs is frequently different, and more concrete, than that of service providers (Morrissey and Levine, 1987; Mulkern and Bradley, 1986). This suggests that more traditional mental health services should be bundled with other services that address people's immediate daily living needs.

Secondly, the developing body of research suggests that aggressive outreach and intensive case management must be keystone services for this

population. Program planners must be sensitive to the extensive amount of time required to engage homeless mentally ill persons in the service system and the stress and fatigue that this causes for front-line workers (Hopper, Mauch, and Morse, 1989). With respect to case management, models that involve low caseloads and long-term support appear to be more successful than models that involve higher caseloads and "brokering" of services (Hopper, Mauch and Morse, 1989).

Housing remains a critical need for homeless mentally ill persons. In many States, the supply of affordable housing is dwarfed by the need for this housing. Clearly, more housing is needed. However, more housing options are also needed. It is becoming apparent that no single type of housing format will meet the needs of all homeless mentally ill persons (Morrissey and Levine, 1987). What is required is an array of housing options with continuing supports that will last indefinitely (Morse, 1985; Roth, 1985; Hopper, Mauch and Morse, 1989; APA Task Force, 1990). Without these continuing supports, the cycle of homelessness is unlikely to be affected.

II. Overview of the Legislation

The Stewart B. McKinney Homeless Assistance Act (P.L. 100-77, as amended by P.L. 100-628, as amended by P.L. 101-645) was enacted by the Congress in July 1987 to provide "urgently needed assistance to protect and improve the lives and safety of the homeless, with special emphasis on elderly persons, handicapped persons and families with children." In the Act, two provisions directly address the needs of persons who are homeless and mentally ill: the Mental Health Services for the Homeless Block Grant (sec.

611) and the Community Mental Health Services Demonstration Program (sec. 612, as amended by sec. 621).

The Block Grant provides funds to each of the States and Territories to implement services designed to relieve the dual conditions of homelessness and mental illness which affect the target population of the legislation. In 1989, 14.128 million dollars was allocated to this program. In contrast to the prior year in which States received grants of varying size according to a formula based on a combined 1987/1988 fiscal year appropriation of 43.689 million dollars, the 1989 grants were set at $267,944 for each of the 50 States, the District of Columbia, and Puerto Rico and $48,717 for the four Territories (Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands).

In order to receive MHSH Block Grant funds, States and Territories were required to submit an application to the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) describing high need geographic areas and services to be provided. All applicants had to execute an agreement assuring compliance with the provisions of the Act, including:

1) an agreement that funds would be spent only for the statutory purposes;

2) an agreement to match federal funds with State or local funds at a rate of $1 to $3; and

3) an agreement not to expend McKinney funds on property costs, inpatient costs, and cash payments to service recipients.

States were required to provide from among six essential services to persons who were severely mentally ill, and who were homeless or significantly

at risk of becoming homeless. Under the provisions (Section 524) of the McKinney Act, these essential services included:

- o Outreach services;
- o Community mental health services, diagnostic, crisis intervention, habilitation and rehabilitation services;
- o Referral to medical facilities for inpatient services, and to provider entities for primary health and substance abuse services;
- o Training to service providers at sites serving homeless people;
- o Case management services including service planning, service coordination, benefits assistance, service referral, and representative payee services; and
- o Supportive and supervisory services in residential settings.

Finally, using a voluntarily agreed upon uniform format, States were required to report annually on the purpose and amount of expenditures.

III. Number and Types of Clients Served

Given the format of the State reports and the preliminary nature of the data contained in these reports, it is somewhat difficult to extract the precise number of clients served through MHSH funded programs. However, the National Association of State Mental Health Program Directors (NASMHPD) recently conducted a telephone survey of the 50 States and the District of Columbia, collecting information on the number of homeless persons with severe mental illness and the number of such persons served by MHSH funded programs (Ross, 1991). Table I (included in Appendix I and entitled, National Association of State Mental Health Program Directors: Results of State Survey) summarizes the data from this survey. Several factors must be considered in interpreting these data. First, in estimating the number of persons who were homeless and mentally ill, the States used somewhat

different definitions. In some cases, States reported the number of persons who had severe mental illness, while others reported the number of persons who required any mental health services at all. Still others reported on the number of persons who had any previous psychiatric hospitalization. Further, some of the estimates refer only to the geographic area served by the MHSH funded programs, while others offered statewide figures. Similar definitional issues complicate the estimates of the number of persons receiving services. In some cases, States reported only those clients receiving MHSH funded services, while others reported clients receiving services from programs funded through other sources.

What is clear, however, is that the MHSH block grant funds enabled the States to reach thousands of individuals with the most challenging service needs, many of whom had been excluded from the service system for substantial periods of time. Overall, States responding to the NASMHPD survey reported 318,699 - 354,907 homeless persons with mental illness. Of this population, 101,972 persons (32%) were served, to some extent, through the MHSH block grant program.

Most of the State MHSH block grant reports included some data on the demographic characteristics of clients served by these programs. Table II (entitled, Number and Demographic Characteristics of Clients Served) summarizes this information from the State reports. It should be noted that the number of clients on which these profiles are based differs somewhat from the NASMHPD figures. This results from the preliminary nature of the data reported in the State documents and somewhat different definitions used in reporting on the NASMHPD survey. As Table II suggests, there are sizable

variations in the client demographic profiles reported by each State. However, it is apparent that the most frequently served clients were white males. While the vast majority of States reported serving more males than females, the relatively large number of women served by these programs (ranging from 13% to 68% of clients served) is a noteworthy achievement. Homeless persons generally have been an underserved group for years, and this has been especially true for women despite the fact that rates of mental illness among homeless women exceed those for homeless men.

Most States reported on the age of clients served, however, differences in the reporting categories used make it impossible to summarize these data accurately or to present the data in tabular format. For those States using sufficiently narrow reporting categories, it is apparent that the clients served by these programs represent a very young population, with a substantial majority under the age of 45 years old.

IV. Needs Assessment, Fund Distribution and Program Selection

States employed various methods for determining local area need for MHSH block grant funds. In the main, the methods utilized fall into four categories.

Several States applied national prevalence rates of homelessness and of mental illness among homeless persons in urban areas to derive a local prevalence estimate. In Massachusetts, California and New York, for example, the prevalence rates employed were those developed under the auspices of NIMH Homeless Research Grants awarded between 1982 and 1986.

Several States simply assumed, absent surveys or prevalence estimates, that most homeless persons were in urban areas. Other States built on the assumption that most homeless persons were in urban areas by conducting a population density analysis based on the 1980 Census. These States then ranked need accordingly. In more sophisticated efforts, States analyzed population density, weighted by social and urban need factors, to derive more informed needs rankings. The State of New Jersey conducted such a weighted mental health and sociodemographic needs analysis, producing a needs ranking for all areas of the State.

Most States conducted or utilized available State or county surveys of homeless people and their needs. In some cases, the surveys involved utilization studies of shelters, meal programs, crisis services, and hotlines. A number of States, for example, referenced their Comprehensive Homeless Assistance Plan (CHAP) as the source of the needs assessment data. South Carolina and Rhode Island, among others, drew figures from surveys undertaken as part of State Mental Health Planning (PL-99-660), NIMH Community Support Homeless Demonstration Grants, and/or NIMH McKinney Homeless Demonstration Grants.

Federal grant initiatives have had a central role in providing the States an incentive and the means to undertake determination of need among homeless persons. Many States relied on national studies or on their own NIMH/federal grant studies to define the scope and nature of need.

In the main, States utilized a range of criteria to distribute MHSH funds within each respective State. These included:

- o Population Density: States often referenced population density as the key criterion utilized in evaluating proposals for MHSH block grant funds. Others reported equity in allocations to urban areas as their guiding principle, in some cases reserving a small amount to distribute to other areas.

- o High Needs Target Areas: Several States, such as New Jersey, structured the selection criteria around the results of their survey analyses and needs assessments. Only applications from the highest ranked need areas, those with the highest percent of citizens in poverty or with housing problems, were funded. A few States required that applicants demonstrate need and awarded funds according to the ranked percentage of the State's homeless and/or chronically mentally ill population.

- o Qualified Agency Type: In other States, the key selection criterion was the type of agency applying for funds. Often, only community mental health centers or State and county mental health entities qualified as applicants. Texas and Virginia were examples of this practice. Entities were in several cases required to meet the States' community mental health program standards to qualify.

- o Formal Review and Award Criteria: In a few cases, States awarded funds based on a competitive bid process, accompanied by a committee review structure utilizing clearly defined award criteria. The award criteria included the factors listed above. Review committees were in some cases the State Mental Health Planning Council; in others, such as Alabama and South Carolina, a specially constituted body of planners and advocates working as part of a State or county homeless task force. Vermont's process was unique in both its carefully drawn selection criteria and in its review group composition. The review group included homeless advocates, providers and mental health consumers.

- o Other Criteria: Other factors utilized by States in the selection process included: designation of target service areas; identification of service gaps; previously neglected areas; local availability of housing; proximity to the State hospital; willingness to serve persons with severe mental illness; experience with serving homeless persons; utilization of research data; and, ability to collect data.

V. Agencies Receiving Funding

A diverse array of agencies received McKinney MHSH grant monies; at least two dozen distinct agency types were reported across the States. The most frequently cited agency type was a non-profit outpatient mental health center. The majority of States chose to develop the capability to serve homeless

persons within the mental health system as opposed to the generic human service system.

The range of agencies receiving funding included:

- o Mental Health Entities: community service boards, community mental health centers, psychosocial rehabilitation centers and psychiatric day centers.
- o Governmental Structures: A State department of human resources and counties.
- o Homeless Service Agencies: drop-in centers, day shelters, multi-service centers, shelters, Salvation Army and Travelers Aid Society.
- o Crisis Services: help hotlines and crisis units.
- o Health Care Organizations: RWJ Healthcare for the Homeless programs, community health centers, a downtown clinic, general hospital and mobile medical units.
- o Housing Programs: a neighborhood development agency, transitional living center and mental health residential programs.
- o Indigenous Community Service Agencies: a community action agency and a diocesan social action agency.
- o Consumer/Family Organizations: mental health consumer-operated drop-in center and affiliates of the National Alliance for the Mentally Ill.

Texas and Virginia are representative of those States exclusively funding their community mental health centers. Vermont is representative of a more diverse approach to funding including mental health, shelter, community action, housing and consumer organizations.

VI. How and Where Key Services Were Provided and Delivered

The State reports summarize the development of numerous programs and service initiatives all aimed at engaging and serving homeless persons with severe and persistent mental illness. The diversity of program models reflect

local needs and the service system context in which the programs operated. As Table III (entitled, Essential MHSH Services Provided) indicates, the majority of States reported providing each of the six essential services. These services are described in the text that follows with examples of State programs cited.

Outreach Services: Outreach services are an essential MHSH requirement because they improve the accessibility of services to homeless mentally ill persons. The effort to make service boundaries more permeable through outreach is twofold. The first aspect is to contact potential clients in the places where they congregate, work to engage them and invite them into service. The second is to bring the services to the potential clients in their own setting, albeit not a traditional service setting.

Most States provided the first aspect of outreach, as described above, through case managers, shelter staff and outreach workers who went to the streets, soup kitchens, shelters and day drop-in centers. For example, Pennsylvania employed formerly homeless consumers as outreach workers to the streets, shelters and meal sites. These consumer outreach workers developed a unique rapport with homeless individuals, assisting with referrals and life skills training. In other States, comprehensive services were brought to homeless mentally ill persons through case management teams. Mobile community treatment teams comprised of physicians, nurses, mental health counselors, substance abuse counselors and case managers engaged clients on the street and in shelters and provided them with direct service and assistance with healthcare, medication, benefits and housing in several States' programs. In New York, mobile outreach was utilized as the model to provide case management and psychiatric intervention. A Visiting Psychiatric Service

operated in New York City serving clients found on the streets and in shelters, drop-in centers and health clinics. One program in Ohio conducted outreach services via a medical mini-van staffed by a psychiatrist, nurse, and social worker. Through this mechanism, a host of physical and social services were immediately available and problems related to service accessibility were eliminated.

Community Mental Health Services: The majority of States provided community mental health services to homeless mentally ill persons through their existing service structures. Community mental health centers were the predominant providers of diagnostic, crisis, habilitation and rehabilitation services. The emphasis in the reports from the States was on the provision of assessment, crisis and medication services. Some community mental health providers offered counseling and support groups.

Few States' reports addressed habilitation and rehabilitation services directly, although Pennsylvania offered life skills training to homeless mentally ill individuals. Several grant recipients providing community mental health services were psychosocial rehabilitation agencies. These agencies were more often described as providing drop-in or day centers where a number of habilitation and rehabilitation activities could be offered. Illinois developed a day program and social drop-in center where a variety of functions, including case management, were provided to homeless mentally ill persons.

Referral to Health and Substance Abuse Services: Case managers, mobile community treatment team staff and community mental health center staff were active in referring homeless mentally ill individuals to inpatient

psychiatric, detox and general hospital medical services. Some providers coordinated closely with the local State hospital. Others worked with Robert Wood Johnson Health Care for the Homeless programs and community health centers to access primary care and tertiary medical services. Little was reported about referrals to community-based substance abuse treatment programs, despite reports of high numbers of mentally ill persons with co-occurring substance abuse disorders. Several States, including New York, Virginia and Florida, identified the availability and accessibility of substance abuse services to the target population as problematic.

Training: Training requirements of the legislation were addressed in several ways. States most often developed training for case managers and outreach workers in the key competencies required to meet the needs of homeless persons with mental illness including information about mental illness, treatment, public benefits, housing and social service resources.

In some cases, training was restricted to providers in the MHSH funded programs. In others, training was provided on a statewide basis and representatives from numerous agencies beyond the mental health field were included. Alabama, for example, conducted training sessions for all staff providing services to homeless mentally ill persons in MHSH funded programs. Training focused on identifying homeless mentally ill persons, identifying programs to which clients might be referred, and referral techniques. In addition, special training attention was given to case management functions including outreach efforts, developing individual service plans for homeless mentally ill clients, providing and brokering support services, obtaining

entitlements, treatment referrals, representative payee services, crisis intervention, and service monitoring.

California adopted a slightly different strategy and elected to use MHSH funds to conduct state-wide training. Two types of training were provided: training service providers to increase housing opportunities for homeless mentally ill individuals, and staff training in service delivery issues. Training on how to increase housing opportunities focused on identifying the housing needs of the homeless mentally ill population, applying for State Department of Housing and Community Development housing funds, site identification, acquisition and development, overcoming community resistance, securing additional development funds, determining the cost-effectiveness of programs, developing housing-related community support programs and identifying ongoing funding sources, and identifying new community groups willing to develop housing for persons with mental disabilities. The staff training component was directed at mental health staff, consumers involved in self-help, contract providers, local community agency staff, community residential care facility staff, shelter operators and law enforcement personnel. Training issues covered included outreach, community mental health services, referrals to medical facilities, case management services, and supportive and supervisory services to homeless individuals in residential settings. Approximately 350 to 400 persons received training.

In Nebraska, Creighton University and the University of Nebraska Medical Center provided training to Omaha area providers. As part of this effort, they developed and distributed three manuals. The topics covered

included: mental illness and medications, local resources, and communication skills and suicide crisis.

Case Management: The McKinney legislation mandated several critical functions for case management for persons who are homeless and mentally ill, including the development of service plans, the coordination of services and the direct provision of services. The majority of States reported carrying out each of the three functions.

Case management efforts varied by State in terms of both program design and staffing. Several States, such as Rhode Island and Wisconsin, operated comprehensive homeless case management teams or mobile community treatment teams. Colorado was unique in its exclusive employment of mental health consumers, some of whom were once homeless, as case manager aides in serving the target client population. Puerto Rico's system employed medical students as the trained case managers in its program.

Some programs offered case management services through a predominantly "facility based" model. Others, however, adopted an "in-vivo" model, delivering case management, support, and treatment in shelters, parks, soup kitchens, drop-in centers, on the streets, in jails, and any other place where homeless people congregate. One Maryland program, for example, was targeted to persons in the County Detention Center who are at risk of homelessness upon release. Case management and treatment services were provided at the detention center and were continued in the community upon the individual's release.

Supportive and Supervisory Services in Residential Settings: The creative combination of federal and matching funds supported States' efforts to address this provision of the legislation. Some States actually developed and operated crisis, transitional and permanent residential programs for the target population. American Samoa and West Virginia developed adult foster care placements which they supported and supervised. A number of States, including Oregon and Vermont, organized housing assistance programs and offered outreach and stabilization support to individuals placed in independent housing.

Overall, the majority of services provided by the States during FY89 were new. In several States, the program initiatives represented expansions of existing services. A small number of States reported providing a continuation of services developed in previous fiscal years.

VII. Consumer, Family and Professional Involvement

A few States noted the involvement of consumers and/or family members as a complement to the professional workforce in service planning and monitoring as well as in service delivery. California involved consumers at several stages of its project. Applications to conduct training were reviewed by a committee composed of Department staff as well as consumer representatives. This committee made recommendations to the Director of the Department of Mental Health. In addition, formerly homeless persons with serious mental illness reviewed the training agenda prior to implementation and consumers and family members participated in the training sessions both as trainees and as presenters.

The Kentucky report noted that consumers and family members were involved in reviewing State plans and services for individuals who are homeless and mentally ill. Vermont also utilized consumers in this role.

Finally, a number of States reported that consumers were employed by the MHSH funded programs and were involved in direct service provision. New York and Ohio reported one program each that was using consumers as direct care staff. Colorado used its entire MHSH grant allocation to fund its Consumer Case Manager Aide Training and Placement Program. Through this program, former mental health consumers received six weeks of training and a three month field internship. They were then placed as employees in one of the State's mental health centers where they provided the following services to homeless mentally ill clients: outreach, crisis intervention, assessment, service planning, service implementation, referrals, linking, monitoring and follow-up, and case finding. Pennsylvania reported two programs employing former consumers as direct care staff. In one, a consumer, who was formerly homeless, was being trained to deliver outreach, habilitation/rehabilitation services, and referral services to homeless clients. In another program three consumers were working as housing support aides. In Vermont, two programs noted that former consumers were working as peer support workers and peer counsellors.

VIII. Coordination of Services and Resources

Effective coordination of services for homeless persons with severe mental illness requires coordination of services and resources at both the client and the system levels. Virtually all States reported both levels of coordination activities.

At the client level, case managers were cited as having coordination responsibility as a major activity. This involved contact and building of relationships with a diverse array of community service entities working to meet the needs of homeless people. Agencies cited as coordination points in the States' reports included: shelters, food programs, Health Care for the Homeless programs, hospitals, Visiting Nurse Associations, YMCAs, transportation authorities, churches, legal service organizations, jails, housing authorities and landlords.

In addition, coordination activities on behalf of clients involved substantial interagency work among the State human service bureaucracies, or their local offices, including the Departments of Mental Health, Human Services, Social Services, Vocational Rehabilitation, and Community and Economic Development. In Virginia, interagency case reviews were conducted at the local level. In Texas, each program site formally assessed the need for internal and external coordination and developed an action plan. Ohio provided central Department of Mental Health technical assistance to the field in coordinating services and resources.

At the State level, most coordination was managed through homeless task forces, often appointed by the Governor. Composition of these task forces included State human service agencies, the homeless coalitions, and consumer advocacy groups. Some bodies held public hearings on the issues of homelessness, conducted formal needs assessments, established coordinating committees, and developed interagency working agreements. As noted earlier, Alabama had a coordinated planning, service development and data evaluation

body. South Carolina's interagency group initiated a joint needs assessment and conducted joint training in the field.

IX. Monitoring and Evaluation

For most States, the monitoring and evaluation of the MHSH funded programs followed the standard procedures for all mental health programs funded in the State. The vast majority of States used a combination of statistical reports from programs and program site visits to perform their monitoring functions.

Requirements for the statistical reports typically included data on the number of clients served, demographic characteristics of clients and expenditure reports. Some States also required that programs report on the units of service provided.

Three States, New Jersey, Kentucky and Connecticut reported using performance monitoring systems in which actual performance was measured against a set of goals. In these States, the performance criteria were related, at a minimum, to the number of clients served and the units of service provided.

In most States, the bulk of monitoring and evaluation activities were conducted by staff from the Department of Mental Health. In a few States, however, a broader spectrum of interests were involved in these activities. In Connecticut, for example, project monitoring was done collaboratively by the Regional Offices of the Department of Mental Health and the Regional Mental Health Boards. In Idaho, consumers teamed up with CMHC program managers and staff to conduct semi-annual project reviews. Vermont

constituted a special panel composed of providers, Department of Mental Health staff, and consumers to select programs and to monitor program performance. Finally, in Louisiana, the Department of Mental Health contracted with the Louisiana Alliance for the Mentally Ill to monitor MHSH programs.

Some States also reported that, in addition to routine monitoring of projects, special evaluation studies were conducted. In the Virgin Islands, for example, a longitudinal study was conducted in which program participants were followed for the duration of the project and changes in lifestyle were documented. In Rhode Island, the Mobile Treatment Team, one of the State's MHSH funded programs, was evaluated by the Rhode Island Psychiatric Research and Training Center, a unit within the Division of Mental Health. This evaluation was a follow-up study of dually diagnosed individuals and collected information on employment, housing, legal involvement, emergency contacts, hospitalization and detoxification.

X. Achievements and Problems

The MHSH block grant funds have provided States with the opportunity to develop and expand innovative service delivery strategies and to improve the lives of persons who are homeless and severely mentally ill. Some examples cited in the State reports will serve to illustrate the magnitude of this impact. Connecticut, for example, noted that prior to the 1989 MHSH block grant project, only 16 of the 22 areas in the State designated as the areas of highest need were offering services dedicated specifically to homeless persons with serious mental illness. The 1989 allocation allowed the State to expand services into three areas (encompassing 44 cities and towns) which previously

had no such specialized services. The Georgia report noted that the mobile nursing clinics, funded with MHSH block grant funds, were successful in improving access to services for homeless mentally ill individuals who were difficult to engage with more traditional service modalities.

A number of State reports provided quantitative evaluation data on the success of programs. Rhode Island, for example, cited the results of an evaluation of their mobile treatment team conducted by the Psychiatric Research and Training Center, a unit of the Division of Mental Health. This longitudinal study of 33 dually diagnosed homeless individuals documented success in several areas including: improved housing stability, a 66% decrease in contacts with the criminal justice system, a 50% reduction in crisis contacts, a 60% reduction in hospital admissions, and a 75% reduction in the use of detoxification services. Similarly, Michigan reported evaluation data on 14 clients from one program. These clients used 546 days of hospitalization during the year prior to entry into the program and only 117 days while in the project. Finally, the Texas report provided data on the integration of clients served in MHSH funded programs into the permanent service system. Eighteen percent of clients served were referred to non-block grant funded programs and an additional 15% were referred to programs that were partially funded with block grant funds but were operating within the permanent service system.

In addition to these notable successes, the reports also document continuing problems and frustrations that plague those attempting to serve this extremely vulnerable population. Some States noted that their efforts to evaluate program performance were hampered by the lack of a statewide client

tracking system. This made it difficult to arrive at unduplicated counts of clients served and to document more than the most rudimentary demographic and clinical data on clients. In addition, the nature of service delivery to homeless mentally ill clients, occurring as it often does on the street, in alleys, or in congested shelters, makes it difficult to collect data in any systematic fashion. Nebraska noted a considerable achievement in this area. One project funded with MHSH block grant funds developed a client tracking system to enhance service coordination, and service linkage and monitoring for all MHSH funded programs serving homeless mentally ill clients in one region of the State. This tracking system, initiated with 1988 block grant funds, was completed during 1989 and is now operational.

Several States also noted that the co-occurrence of psychiatric and substance abuse disorders presents an extraordinary challenge to service providers. Information in these reports, as well as elsewhere in the literature, suggests that this is a problem of substantial proportions. Texas, for example, noted that 40% of clients served by MHSH funded programs had serious substance abuse problems in addition to their psychiatric disabilities. Similarly, California noted that approximately half of the homeless individuals with chronic mental illness served by the Department of Mental Health had serious substance abuse problems. The Alaska report documented a pressing need for residential programs for persons with co-occurring mental illness and substance abuse disorders. These individuals present a complicated clinical picture and accessing services for them is frequently made even more difficult by the fragmentation of mental health and substance abuse services in many States.

States also reported that transitioning clients from homeless team caseloads to "mainstream" mental health agency case loads were complicated by limitations in service capacity and the philosophical orientations of more traditional service providers. Similarly, transitions from shelters to housing and from transitional to permanent housing were complicated by a lack of available housing and delays in housing development. These gaps and delays thwarted efforts of homeless program staff to provide effectively for the needs of their clients and increased stress and mistrust among a client population that was difficult to engage.

Continuing inadequacies in knowledge about how to engage certain homeless persons, as reported by some programs, were attributed by other programs as due to limitations in the comprehensiveness and skillfulness of individual client assessments. Comprehensive assessments, including evaluation of medical, psychiatric, rehabilitation, housing and entitlement needs, combined with persistence of homeless staff and an ability to deliver services and resources in a timely response to needs, were considered key to addressing those individuals described as difficult to engage or resistant to treatment.

XI. Conclusions

The McKinney legislation and the resources that are provided to the States through the MHSH block grants are important in several ways:

- o They have focused awareness on the population of persons who are homeless and mentally ill and have provided a template, based on NIMH research findings, for the services needed by this population;
- o The legislation has encouraged States to assume responsibility for working with localities to fill gaps in the existing service system;

- o The requirement of a match has helped States to leverage State and local funds to assist this population;
- o As more and more State economies constrict, this federal assistance assumes greater importance.

The State reports on the 1989 MHSH block grant program provide ample evidence of innovative and creative uses of federal assistance in designing and providing services to homeless persons with serious and persistent mental illness. As a result of this funding, many States were able to develop new services and expand existing services to previously unserved or underserved areas and populations.

In addition, these resources allowed States to increase coordination of services at both the client and system level. States brought together numerous interests in the design, provision, and monitoring of MHSH programs. These interests included local advocacy agencies, other agencies of local and State government, and local charitable agencies. Several States also involved consumers in service delivery and oversight roles.

The importance of other federal grant programs was evident in the States' reports of their needs assessment activities. In determining local need, many States relied heavily on data from the NIMH Community Support Program Homeless Demonstration grants, the NIMH McKinney Homeless Demonstration grants, the State Mental Health Planning (PL 99-660) grants, and the HUD Comprehensive Homeless Assistance Plans (CHAP).

States used the federal MHSH block grant funds to develop or expand a wide array of services, all aimed at homeless persons with severe mental illness. Funded programs were most frequently embedded within the mental

health system, as opposed to the generic human service system providing assistance to homeless persons. Providers concentrated most often on outreach, case management and referral. Few States provided quantitative data on the effectiveness of the services funded with MHSH block grant funds. However, those States that conducted formal evaluations were able to document considerable success in the areas of housing stability, hospitalization rates, use of crisis services, use of detoxification services, and integration of clients into the permanent mental health service system.

Several States noted that their monitoring and reporting efforts were hampered by underdeveloped client tracking systems. The NIMH Mental Health Statistics Improvement Program (MHSIP) has been developed in recognition of this deficit and the work currently being conducted under this program should assist States considerably in the development of useful information systems.

In summary, the federal MHSH block grant program has been an important resource for States as they have attempted to meet the needs of homeless adults with severe mental illness. It is anticipated that the new Projects for Assistance in Transition from Homelessness (PATH) formula grant program will provide States with increased opportunities to use federal allocations to develop housing and residential services and to develop stronger linkages among treatment, housing and support services for this population.

APPENDIX I
TABLES

TABLE I
NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS
RESULTS OF STATE SURVEY

STATE	ESTIMATED HOMELESS MENTALLY ILL POPULATION	HOMELESS MENTALLY ILL PERSONS RECEIVING SERVICES THROUGH MHSH BLOCK GRANT PROGRAM	ESTIMATED HOMELESS MI POPULATION WHICH MAY NOT BE RECEIVING MH SERVICES
ALABAMA	2,079	873	1,206
ALASKA	900 - 1,350	92	808 - 1,258
ARIZONA	2,093 - 4,300	485	1,608 - 3,815
ARKANSAS	3,000 - 3,500	1,029	1,971 - 2,471
CALIFORNIA	63,000 - 65,000	20,000	43,000 - 45,000
COLORADO	12,000	3,510	8,490
CONNECTICUT	5,534 - 9,223	4,117	1,417 - 5,106
DELAWARE	20	10	10
DISTRICT OF COL.	1,970 - 2,465	1,250	720 - 1,215
FLORIDA	7,735	1,425	6,310
GEORGIA	4,620	946	3,674
HAWAII	900	600	300
IDAHO	788	718	70
ILLINOIS	20,000	609	19,391
INDIANA	3,600 - 6,000	1,056	2,544 - 4,944
IOWA	4,761	706	4,055
KANSAS	3,600	1,100	2,500
KENTUCKY	1,400	858	542
LOUISIANA	3,834	375	3,459
MAINE	3,750	781	2,969
MARYLAND	1,216	550	666
MASSACHUSETTS	4,467	1,484	2,983
MICHIGAN	11,750 - 31,750	3,600	8,150 - 28,150
MINNESOTA	5,796	3,152	2,644
MISSISSIPPI	1,500	750	750
MISSOURI	5,000 - 8,000	1,800	3,200 - 6,200
MONTANA	970	260	710
NEBRASKA	319	319	0
NEVADA	6,660	1,930	4,730
NEW HAMPSHIRE	3,000	2,000	1,000
NEW JERSEY	7,359	3,445	3,914
NEW MEXICO	400	225	175
NEW YORK	12,000	5,000	7,000
NORTH CAROLINA	2,200	325	1,875
NORTH DAKOTA	441	441	0
OHIO	2,800	1,000	1,800
OKLAHOMA	7,500	2,698	4,802
OREGON	6,621 - 8,083	475	6,146 - 7,608
PENNSYLVANIA	19,014	10,707	8,307
RHODE ISLAND	63	63	0
SOUTH CAROLINA	3,000	500	2,500
SOUTH DAKOTA	1,100	589	511
TENNESSEE	1,200	500	700
TEXAS	40,000	8,788	31,212
UTAH	2,052	450	1,602
VERMONT	1,200	900	300
VIRGINIA	2,556	1,791	765
WASHINGTON	18,320	4,716	13,604
WEST VIRGINIA	996	451	545
WISCONSIN	3,500 - 4,000	2,425	1,075 - 1,575
WYOMING	115	98	17
TOTAL	318,699 - 354,907	101,972	216,727 - 252,935
STATES REPORTING	51	51	51

TABLE II
NUMBER AND DEMOGRAPHIC CHARACTERISTICS
OF CLIENTS SERVED

STATE	NUMBER SERVED	% MALE	% FEMALE	% WHITE	% BLACK	% HISPANIC	% OTHER
ALABAMA (1)	648						
ALASKA (1)							
AMERICAN SAMOA	28	79%	21%	0%	0%	0%	100%
ARIZONA	314	71%	29%	71%	17%	9%	3%
ARKANSAS	350	46%	54%	74%	25%	0%	1%
CALIFORNIA (2)							
COLORADO	3510	52%	48%	76%	8%	8%	8%
CONNECTICUT	519	62%	38%	50%	37%	13%	0%
DELAWARE	36	42%	58%	58%	31%	11%	0%
DISTRICT OF COLUMBIA	65						
FLORIDA (3)	1045	71%	29%	67%	28%	5%	1%
GEORGIA	2496	76%	24%	25%	73%	1%	0%
GUAM	14	50%	50%	0%	0%	0%	100%
HAWAII (1)							
IDAHO	391	45%	55%	95%	0%	1%	4%
ILLINOIS	1079	71%	29%	52%	45%	2%	1%
INDIANA (4)	901	57%	43%	66%	30%	3%	0%
IOWA (1)	706						
KANSAS (5)	1208	53%	47%	69%	27%	2%	1%
KENTUCKY (6)	779	66%	34%	77%	21%	0%	2%
LOUISIANA	38	58%	42%	74%	26%	0%	0%
MAINE	498	61%	39%	99.5%	0.5%	0%	0%
MARYLAND (7)	800	65%	35%	58%	41%	0%	1%
MASSACHUSETTS (1)							
MICHIGAN	862	63%	37%	64%	31%	2%	2%
MINNESOTA	1180	74%	26%	71%	15%	7%	7%
MISSISSIPPI	56	55%	45%	70%	30%	0%	0%
MISSOURI (8)	1903	74%	26%	65%	33%	1%	1%
MONTANA	234	54%	46%				
NEBRASKA (9)	484	54%	46%	80%	10%	3%	6%
NEVADA	117	68%	32%	90%	3%	3%	4%
NEW HAMPSHIRE (1)							
NEW JERSEY (1)	2114						
NEW MEXICO	244	68%	32%	61%	5%	28%	7%
NEW YORK (10)	605	87%	13%	47%	42%	2%	9%
NORTH CAROLINA (11)	209	56%	44%	55%	41%	0%	3%
NORTH DAKOTA	670	60%	40%	74%	1%	0%	25%
OHIO	1521	55%	45%	67%	25%	6%	2%
OKLAHOMA (12)	900	79%	21%	71%	21%	3%	5%
OREGON	132	75%	25%	77%	16%	0%	6%
PENNSYLVANIA	569	50%	50%	63%	34%	3%	0%
PUERTO RICO (13)	4242			0%	0%	100%	0%
RHODE ISLAND (14)	331	67%	33%	56%	31%	11%	1%
SOUTH CAROLINA (15)	157	71%	29%	61%	39%	0%	0%
SOUTH DAKOTA (16)	420	44%	56%	78%	0%	0%	22%
TENNESSEE (1)	423						
TEXAS (17)	6811	62%	38%	44%	43%	13%	0%
UTAH (1)	650						
VERMONT (1)	887						
VIRGIN ISLANDS	24	58%	42%	0%	96%	4%	0%
VIRGINIA	1574	60%	40%	54%	43%	0%	3%
WASHINGTON (18)	1878	32%	68%	84%	10%	6%	0%
WEST VIRGINIA	730	69%	31%	96%	3%	0%	0%
WISCONSIN (19)	2485	75%	25%	65%	29%	4%	1%
WYOMING	96	65%	35%	92%	0%	3%	5%

(1) MISSING CLIENT INFORMATION
(2) TRAINING PROVIDED TO 300–400 PERSONS
(3) TOTALS FROM 3 OF THE 4 PROGRAMS
(4) DEMOS N=700
(5) DEMOS N=430
(6) RACE N=683
(7) GENDER N=598, RACE N=642
(8) TOTALS EXCLUDE 1 PROGRAM, GENDER N=1745, RACE N=1078
(9) TOTALS EXCLUDE 1 PROGRAM, DEMOS BASED ON TOTAL OF 393
(10) DEMOS N=388 (2 OF 3 AGENCIES)
(11) DEMOS N= 164 (ONE PROGRAM MISSING DATA)
(12) GENDER N=563, RACE N=514
(13) TOTAL IS DUPLICATED COUNT
(14) GENDER N=336, RACE N=239
(15) DEMOS N=31
(16) DEMOS N=136
(17) DEMOS BASED ON 5469 REGISTERED CLIENTS
(18) DEMOS N=423 (2 OF 3 AGENCIES)
(19) GENDER N=1387, RACE=1665

TABLE III
ESSENTIAL MHSH SERVICES PROVIDED

STATE	OUTREACH SERVICES	MENTAL HEALTH SERVICES	REFERRAL	TRAINING	CASE MANAGEMENT	SUPPORTIVE SERVICES IN RESID. SETTING
ALABAMA	+	+	+	+	+	+
ALASKA	+	+	+		+	+
AMERICAN SAMOA	+	+	+	+	+	+
ARIZONA	+	+	+	+	+	
ARKANSAS	+	+	+	+	+	+
CALIFORNIA				+		
COLORADO	+	+	+	+	+	+
CONNECTICUT	+	+	+	+	+	+
DELAWARE	+	+	+	+	+	+
DISTRICT OF COLUMBIA *						
FLORIDA	+	+	+	+	+	+
GEORGIA	+	+	+		+	
GUAM		+		+		
HAWAII **						
IDAHO	+			+	+	
ILLINOIS	+	+	+	+	+	+
INDIANA	+	+	+	+	+	+
IOWA	+	+	+	+	+	+
KANSAS	+	+	+	+	+	+
KENTUCKY	+	+	+	+	+	+
LOUISIANA	+	+	+	+	+	+
MAINE	+		+	+	+	+
MARYLAND	+	+	+	+	+	+
MASSACHUSETTS	+	+	+	+		
MICHIGAN	+	+	+	+	+	+
MINNESOTA	+	+	+	+	+	+
MISSISSIPPI	+	+	+		+	+
MISSOURI	+		+	+	+	+
MONTANA	+	+	+	+	+	+
NEBRASKA	+	+	+	+	+	+
NEVADA	+	+	+	+	+	+
NEW HAMPSHIRE *						
NEW JERSEY	+	+	+	+	+	+
NEW MEXICO	+	+	+	+	+	+
NEW YORK	+	+	+	+	+	
NORTH CAROLINA		+	+	+	+	+
NORTH DAKOTA	+	+	+	+	+	+
OHIO	+	+	+	+	+	+
OKLAHOMA	+	+	+		+	+
OREGON	+	+	+	+	+	+
PENNSYLVANIA	+	+	+	+	+	
PUERTO RICO	+		+	+	+	
RHODE ISLAND	+	+	+	+	+	+
SOUTH CAROLINA	+	+		+	+	+
SOUTH DAKOTA	+	+	+	+	+	+
TENNESSEE	+	+	+	+	+	+
TEXAS	+	+	+	+	+	+
UTAH	+	+	+	+	+	+
VERMONT	+	+	+	+	+	+
VIRGIN ISLANDS	+	+	+	+	+	
VIRGINIA	+	+	+	+	+	+
WASHINGTON	+	+	+	+	+	+
WEST VIRGINIA	+	+	+	+	+	+
WISCONSIN	+	+	+	+	+	+
WYOMING	+	+	+	+	+	+

* NO INFORMATION ** NEW PROGRAM

REFERENCES

American Psychiatric Association Task Force on the Homeless Mentally Ill. General Directions for Public Policy in Behalf of the Mentally Ill Among the Homeless Population. Washington, D.C. Spring, 1990

Burt, M.R. and Cohen, B.E. America's Homeless: Numbers, Characteristics and Programs that Serve Them. Urban Institute Report 89-3.

Fischer, P.J. Criminal Behavior and Victimization in the Homeless: A Review of the Literature. In R. Jahiel (Ed.) Homelessness: A Prevention-Oriented Approach. Baltimore: Johns Hopkins Press, 1989.

Fischer, P.J., and Breakey, W.R. Homelessness and Mental Health: An Overview. International Journal of mental Health. Vol. 14, No. 4, 1986, pp. 6-41.

Hopper, K., Mauch, D., Morse, G. The 1986-87 NIMH-Funded CSP Demonstration Projects to Serve Homeless Mentally Ill Persons: A Preliminary Assessment, August, 1989.

Levine, I. S., Homelessness: Its Implications for Mental Health Policy and Practice. Prepared for the Annual Meeting of the American Psychological Association. August 30, 1983,

Morse, G., Shields, N.M., Hanneke, C.R., Calsyn, R.J., Burger, G.K., and Nelson, B. Homeless People in St. Louis: A Mental Health Program Evaluation, Field Study, and Follow-Up Investigation. Jefferson City, MO: Missouri Department of Mental Health, January, 1985.

Morrissey, J. P. and Levine, I. S., Researchers Discuss Latest Findings, Examine Needs of Homeless Mentally Ill Persons. Hospital and Community Psychiatry, Aug., 1987, Vol. 38, No. 8, pp. 811-812.

Mulkern, V. and Bradley, V.J. Service Utilization and Service Preferences of Homeless Persons. Psychosocial Rehabilitation Journal, Vol. X, No. 2, Oct., 1986.

Robertson, M. J., Mental Disorder Among Homeless Persons in the U.S.: An Overview of Recent Empirical Literature. Administration in Mental Health, Vol. 14, No. 1, Fall, 1986. pp. 14-26.

Ross, C., Mental Health Services for Homeless Persons: Estimates of Need and Persons Served. Study # 91-689. National Association of State Mental Health Program Directors, Alexandria, VA., April, 1991.

Roth, D., Bean, J., Lust, N., and Saveanu, T. Homelessness in Ohio: A Study of People in Need. Columbus, OH: Ohio Department of Mental Health, 1985.

Salem, D.A. The Mental Health Services for the Homeless Block Grant Program: A summary of FY 1987/1988 Annual Reports. National Institute of Mental Health, Rockville, Md. April, 1990.

Salem, D. A. and Levine, I. S. Enhancing Mental Health Services for Homeless Persons: State Proposals under the MHSH Block Grant Program. Public Health Reports. May-June, 1989, Vol. 104, No. 3.

Tessler, R.C. and Dennis, D.L. A Synthesis of NIMH-Funded Research Concerning Persons who are Homeless and Mentally Ill. Rockville, Maryland: National Institute of Mental Health, 1989.