

Keeping People with MH/SA Problems off the Streets: Prevention Strategies Work

“If you implement strategies, you can keep people in housing.” To Director of Clinical Initiatives for CMHS’ Homeless Programs Larry Rickards, that is the bottom line of the recently concluded CMHS/CSAT study on the prevention of homelessness.

Just concluded, the five-year, \$4.8 million project studied eight programs using a variety of strategies to combat homelessness.

According to Rickards the programs that provided housing along with services tended to have good results relative to their own control groups. For example, in New York City’s Pathways Program, the number of study clients still in housing at the end (88%) was almost double the control group (47%).

Targeting a population that was mentally ill with SA histories (90% were dually diagnosed), Pathways set out to compare a new approach that honored consumer choice with New York’s linear continuum of care system. Continuum of care provides consumers with a step by step progression of services, starting with outreach, moving on to treatment and ending with housing six to 18 months later. According to Pathways Director Sam Tsemberis, the linear system “does well, people manage to go through all those hoops but it’s not totally effective.”

Pathways randomly assigned 225 people from the street to be in a control group or to participate in the experiment. As a starting point consumers in the experimental group were asked what they wanted and when 95% requested places to live, they were allowed to choose their own apartments, roommates, if they wanted them, and furnishings. “We are trained to believe that people are unable to make choices for themselves, that they need skills to live in houses,” says Tsemberis. “It’s absolutely bogus.” Only two conditions were set: clients had to see their service coordinators two times a month and pay 30% of their SSI checks towards rent, as part of a money management plan.

In actuality, says Tsemberis, clients saw different members of Pathways’ interdisciplinary teams several times a week to address MH, SA, medical, vocational

and other problems. The team members included consumers, who provided a model of recovery for both clients and staff.

Pathways found that people liked and accepted the new system, which also reduced or eliminated access problems. “Mostly people need time, it’s a compassionate approach,” says Tsemberis. Under Pathways’ harm reduction approach to drug use, which does not require abstinence, clients, who relapsed, were not penalized by loss of housing. Nor did they have to start all over again as they would have had to do in the linear system.

The CMHS/CSAT study only measured outcomes for 12 months, not enough to evaluate treatment. However, the state of New York is continuing to fund Pathways. Having established that the homeless can successfully retain housing, Tsemberis would like to see how consumers fare in terms of recovery. The outlook is thought to be good. More than 65% of Pathways tenants receive treatment from the program’s psychiatrist.

While Pathways and the other sites in the CMHS/CSAT study will be publishing their own findings, Rickards says a cross site analysis will be made as soon the individual reports are in and that this will be reviewed for policy implications. One place where the study is likely to have an impact is SAMHSA’s ground-breaking strategic plan for homelessness to be completed by the end of the year. The plan is the first time SAMHSA has set out guidelines for stakeholders. Tsemberis praises the design of the SAMHSA study for its universal applicability. Random assignment of subjects, he says, negates any argument that the consumer choice model wouldn’t work in other places.

In addition to Pathways, grantees for the SAMHSA study included a **Philadelphia Health Management Corporation** project, providing housing intervention with support services; the **Barbour and Floyd Medical Associates program in Lynwood, CA**, helping families care for family

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members with serious MI and co-occurring SA; **Chicago's Community Counseling Centers client bank**, handling money management problems for consumers with serious MI and SA problems; **Community Connections in Washington, D.C.**, providing a continuum of housing options to clients with serious MI and co-occurring SA; a **Gaudenzia, Inc. residential program in West**

Chester, PA, targeting mothers recovering from SA, living with their children; **Arapahoe House Inc. PROUD Project in Thornton, CO**, featuring case management for dually diagnosed women; and the **Boley Center for Behavioral Healthcare, Inc. of St. Petersburg, FL**, running a cluster of housing-related support services for persons with serious MI and co-occurring SA.

November 1, 2000

Dear NACBHD Members:

This issue finds our 2001 Membership Campaign underway. I would like to take this opportunity to encourage each of you to renew your membership in NACBHD for next year. As you have been following through your newsletters and conference programs, this past year's activities have been impressive. Our voice in the national public policy discussion is being heard. We are influencing legislation on appropriations, parity, patients' rights, seclusion and restraints, and juvenile justice. With our partnering organizations, we are tackling the critical issue of integrated treatment for patients with co-occurring disorders. We have voiced our concern over HCFA's choice of plans regulations, and are closely monitoring the Medicaid waivers in key states such as New York, Pennsylvania and Michigan.

With Workforce Issues in the Behavioral Healthcare Arena as the theme for both the 2001 Legislative and Annual Conference, we look forward to providing you the information, perspective and time for idea exchange that can help you take control of this urgent concern.

Please take a moment to complete the membership application in this newsletter and mail it to us with your payment. If you have already renewed, thank you very much for your continuing investment. Pass this issue and the application to a colleague. Spread the word about the importance of NACBHD membership too all county authority directors.

Finally, use the organization. Speak up; get involved; let us know how we are doing and how you would like to contribute. Pull up our web site at www.nacbhd.org. Use the Members Only Section to compare thoughts and get ideas from other members. Thank you all for your commitment and support. I look forward to meeting you and working with you in the coming year.

With warm regards,



*William P. Harper, MSW, MA
President*



Bulletin

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of the month prior to publication. Please submit copy by email to Dr. Sandra Naylor-Goodwin: sgoodwin@cimh.org Molly McKittrick: mcmckit@erols.com.

NACBHD is an affiliate of the National Association of Counties.

SA is a Leading and Growing Cause of Homelessness

Behind affordable housing, SA is the second biggest cause of homelessness. This was the finding of the 1999 National Survey of the US Conference of Mayors, last December. By contrast mental illness is fifth on the list. Reporting on homelessness in 26 cities the 15th annual survey also found that demand for emergency housing had grown at its greatest rate in six years.

“We feel there’s an increase in the (SA) problem because we haven’t come up with a program that works in that area,” says National Coalition for the Homeless Health Policy Analyst Bob Reeg. State addiction programs, he adds, have not demonstrated a full commitment to tailor their services to the homeless. Cost considerations dictate flexible treatment models that favor outpatient treatment and while this is “healthy over all, it doesn’t serve our population the best,” says Reeg.

The system, he believes, works better on the MH side, perhaps because of stigma. “There’s a higher sympathy factor for the mentally ill on the street, whereas the attitude towards the homeless addict is maybe they did it to themselves,” he says. While Reeg

maintains there’s still a need for MH services and housing, he thinks the federal commitment on that side is stronger than in the SA area.

According to Reeg, the overall rise in homelessness can be attributed to the shortage of affordable housing, a shortage that is growing in the strong economy as landlords find they can charge market and above market rates. “The situation definitely speaks to the need for supportive housing,” he says. While Reeg maintains that SA and MH agencies should not have to use their funds for housing, he is troubled by the lack of a non profit or public partner to develop the housing piece.

The US Conference of Mayors survey showed that the homeless population has changed little in recent years with single men comprising the largest group at 43 percent and families with children, 37 percent. Thirty-one percent were reported substance abusers.

Ninety-two percent of survey participants said they expected the housing problem to worsen in 2000. According to the federal Interagency Council on the Homeless up to 600,000 people are homeless every night in the U.S.

A CA Experiment to Aid the Mentally Ill Homeless Shows Results

Fewer hospitalizations, incarcerations and days spent homeless are the outcomes of a pilot program aimed at homeless people, parolees and probationers with serious mental illness in three CA counties (see Sacramento below). After five months the results of intensive, integrated outreach and community-based services were dramatic. Compared with data collected over the 12 months before the pilot services began, they show

- Hospitalizations after enrollment dropped 64.2%;
- Days of incarceration dropped 73%; and
- Days spent homeless fell 58.92%.

CA allocated ten million dollars to fund programs in L.A. County (\$4.8 million), Sacramento County (\$2.8 million) and Stanislaus County (\$1.9 million). The differences in funding reflect the varying costs of housing in the three participating counties.

Each county had to agree to start a new program with the money, rather than funding existing services. Also, each had to submit a work plan, detailing fund expenditure, the number of clients to be served and what outreach methods would be used. During the five month study period fewer than 15% of eligible clients

refused enrollment in the programs while the percentage dropping out was less than four percent.

Average outreach cost per client was \$8,513, which represents a savings to the CA taxpayer. Because many in the targeted population had not had access to MH services, their MH needs were addressed only when they reached crisis levels and required expensive, lengthy hospitalizations with a probability of relapse since there were no follow up services. Many in the targeted group had had contact with the criminal justice system for crimes like vagrancy, littering and disturbing the peace and this too is costly. In CA the Department of Corrections spends approximately \$400 million annually for incarceration and treatment of people suffering from MI and an additional \$300 million for state mental hospitals.

After five months the tri county experiment was so successful that the programs have now been funded permanently. Legislation has also been introduced to increase the treatment teams in those counties and develop others. There are an estimated 50,000 homeless Californians with mental illness.

In Montgomery Co., MD, Lack of Housing May Jeopardize Study

“The idea was that if we rented and subsidized apartments it would be easier to get (homeless mothers) into treatment and monitor treatment.” This assumption by Montgomery Co. Clinical Supervisor Kim Ball was not unfounded because the county had already had success with a program that places families in temporary housing (12-18 months) while providing intensive integrated treatment. The idea was to expand on it as part of SAMHSA’s Homeless Families Study.

Still in the protocol stage, the joint CMHS/CSAT study will document “the effectiveness of time-limited (6-9 months), intensive intervention strategies to provide treatment, housing, support and family preservation services to homeless mothers with psychiatric and/or substance abuse disorders, who are caring for dependent children.” A year ago \$3.5 million in grant money was distributed to 14 sites, including Montgomery Co.

To get a good study sample Ball says she needs to house 15 homeless families to add to the five in the pre-existing program. So far she has managed to find apartments for four. The problem is the economy, which has rendered rental housing very scarce - the county has a one percent vacancy rate - and very expensive. According to Ball, an average three bedroom apartment costs \$1100, while most homeless mothers are getting monthly cash assistance of about \$1500. Even with county subsidization, she says, landlords choose not to rent to women on public assistance, who often have criminal records.

Compounding the problem is that county halfway houses are not a good alternative for most families. Holding a maximum of 20 people, they limit families to one or two children. There is also an age cut off of ten.

“We could put a 12 year old in protective services,” says Ball, “but that doesn’t help (the mother).”

If the degree of difficulty is not wide enough, Ball also got a late start. The County Council, which had to approve her grant, took four months to do so, so the money, granted by SAMHSA in November did not become available until February. Now, her clients are on the waiting list for Housing Opportunities Commission apartments and she is hopeful that SAMHSA will be patient.

According to Larry Rickards with CMHS’ Homeless Programs, finding appropriate placement for homeless individuals is tough and getting tougher in many communities, especially those that are more affluent, where housing costs are at a premium. But, says Rickards, those communities are just as likely as poorer ones to have a homeless population.

The SAMHSA study will measure demographics, pathways to homelessness, SA and MH treatment, improvements in functioning by both mothers and children, parenting skills and social skills. Ball is also hopeful that the study will shed light on problems in current federal laws that she thinks are damaging to her clients. For instance, most homeless shelters require that women be separated from their husbands to receive services. They also stipulate that consumers have no criminal backgrounds or be off probation for three years. This prerequisite also extends to section 8 housing and food stamps. Another federal requirement that bugs Ball is the linkage of SA and MH problems. Many of her consumers have addiction problems but no mental illness. Yet, she says, they are forced to demonstrate mental illness in order to receive social security assistance.

Congress Funds Grant Program to Help the Homeless

Community based entities can compete for funding to treat the homeless under the newly funded Grants for the Benefit of Homeless Individuals (GBHI). Previously established by Congress the program was never funded. Now ten million dollars has been allocated to the Department for Health and Human Services for services to treat the homeless. The program is likely to devolve to SAMHSA.

Also, under the SAMHSA Reauthorization Bill, funding for the Projects for Assistance of Transition from homelessness (PATH) program has been increased by more than \$5 million. Receiving \$37 million for the next year, PATH is a formula grant program to states that pays for outreach, case management, DD treatment and limited housing.

**THE NATIONAL ASSOCIATION OF COUNTY BEHAVIORAL HEALTH DIRECTORS
2001 MEMBERSHIP APPLICATION**

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Make check payable to: National Association of County Behavioral Health Directors (NACBHD).

Return This Form with Your Payment to: NACBHD, PO Box 75486, Baltimore, MD 21275

CALCULATION OF DUES

NACBHD dues are based on the size of your organization's annual expenditure budget (most recently concluded fiscal year) for mental health, substance abuse, and developmental disabilities, or any combination of the three. Subtract any non-behavioral health portions of your budget (e.g. corrections, aging, social services). Please check the appropriate box below to identify your dues.

Annual Budget		Dues
<input type="checkbox"/>	\$0 - \$ 5,000,000	\$250
<input type="checkbox"/>	\$5,000,001 - \$10,000,000	\$350
<input type="checkbox"/>	\$10,000,001 - \$15,000,000	\$400
<input type="checkbox"/>	\$15,000,001 - \$20,000,000	\$500
<input type="checkbox"/>	\$20,000,001 - \$30,000,000	\$600
<input type="checkbox"/>	\$30,000,001 - \$40,000,000	\$700
<input type="checkbox"/>	\$40,000,001 - \$50,000,000	\$800
<input type="checkbox"/>	\$50,000,001 - \$60,000,000	\$900
<input type="checkbox"/>	Over \$60,000,000	\$1,000
<input type="checkbox"/>	State Association	\$250
<input type="checkbox"/>	Associate Membership (Non-County Authority Members)	\$250

NACBHD'S 2001 LEGISLATIVE CONFERENCE

FEBRUARY 28 - MARCH 2ND

HOLIDAY INN ON THE HILL, WASHINGTON, DC

Don't miss the best forum for the latest, most critical policy information directly affecting county/local behavioral health authorities! Our new location on Capitol Hill will afford you the opportunity to hear from legislators and their staff members on key behavioral health legislation, and speak with your own congressional delegation.

MARK YOUR CALENDAR

CMHS ANNOUNCES Mental Health Services Grant Awards

In observance of last month's Mental Illness Awareness Week (October 1-7th), CMHS has awarded \$30 million in new mental health service grants to communities across the country. "These grants provide hope for improving the quality of life for people living with mental illness and their families", said CMHS Director, Bernard S. Arons, MD. To summarize the grant and contract categories:

- 1. National and Statewide Coalitions To Promote Community Based Care** - \$6.6 million three year contracts to promote community-based services in keeping with the Olmstead decision.
- 2. The Community Assessment and Intervention Center** - \$3.3 million project to provide single-point of entry for referral of youth in four Florida localities with substance abuse, mental health and/or behavioral health problems.
- 3. Coalitions for Prevention Grants** - \$7.4 million program awarded to 29 states, cities and counties to develop partnerships to sustain service systems to youth violence prevention and mental health promotion.
- 4. Cooperative Agreements for Comprehensive Community Action Grants to Promote Youth Violence Prevention, Suicide Prevention and Resilience Enhancement** - \$4.1 million in new cooperative agreements to 29 communities to implement evidence-based youth violence/suicide prevention programs.
- 5. Family Strengthening Initiative** - \$3.1 million jointly funded with CSAT focusing on strengthening effective parenting and family programs to reduce or prevent substance abuse and violence.
- 6. Technical Assistance Center for Evaluation of Mental Health Systems Change** - \$650,000 continuing grant to provide technical assistance to states, and local and non profit organizations with a primary focus on adult mental health systems.
- 7. Community Action Grant Program** - \$3.6 million supporting 26 grants to local communities to adopt exemplary, proven practices for adults with serious mental illness and children with serious emotional disturbances.

PUBLICATIONS AVAILABLE

Cultural Competence Standards: In Managed Health Care Services: Four Underserved/Underrepresented Racial/Ethnic Groups: Final Report from the Working Group on Cultural Competence in Managed Mental Health Care Services, sponsored by the Center for Mental Health Services, SAMHSA, 1998.

To order call the CMHS Knowledge Exchange Network (KEN): 1-8-00-789-2497 or visit their web site at www.mentalhealth.org to view the standards online.

CANDIDATE BRIEFING PAPER, developed by The Mental Health Liaison Group Available upon request from the NACBHD office

Available at no charge from The National GAINS Center - Program brief - *Creating Integrated Service Systems for People with Co-Occurring Disorders Diverted from the Criminal Justice System: The King County(Seattle) Experience*

Paper - *Creating Effective Treatment Programs for Persons with Co-Occurring Disorders in the Justice System"*

You can order directly from the National GAINS Center, 345 Delaware Avenue, Delmar, NY 12054; 1-800-311-GAIN or FAX: (518) 439-7612. They have other publications available. Request their list.

In Sacramento “We Said We Would Do Whatever it Takes”

And what it took, according to MH Program Coordinator Frances Freitas, was addressing all of her homeless clients' needs from housing to treatment to medical and dental care. As part of the three county pilot to treat the mentally ill homeless (see above) Sacramento Co. established two intensive integrated treatment teams serving 100 clients apiece 24 hours a day, seven days a week. On any given day three or four treatment specialists are on duty.

Most importantly, the program offered immediate housing, something it was able to do either in licensed bed and care facilities or in rented dwelling spaces. There was enough funding to cover rental costs. Provision of housing, according to Freitas, was the lynchpin upon which all other services rested because “it was the number one critical issue in terms of engaging the person.” Also, as long as clients put almost total energy into survival on the streets, they had little left over to address other problems.

“Many things we knew intuitively were borne out by the study,” Freitas says. For instance, while this popula-

tion had good street skills, it had less know how about practical day to day living in a safe environment. Thus, social skills were addressed in a series of outings: movies, picnics and bowling. Life skills, such as managing money and riding the bus, also had to be taught.

On top of day to day skills was the problem of SA, which, according to Freitas, “compounds and confounds” the homeless issue. A significant number of her consumers have drug and/or alcohol goals. They work with the medical team and also attend 12 step programs and dual diagnosis recovery groups

Freitas says that recent support for programs to help the homeless is largely attributable to the good economy. As it flourishes, a gutted MH system is slowly being re-funded. She adds that the money is being put back better than when it was taken away and that counties and others are approaching their work with the homeless with both hope and encouragement. While she cautions that housing is still a huge unmet need, she says, “I’ve been doing this work for a billion years and I can’t remember when I’ve been so excited.”

SAMHSA Reauthorization Bill Passes

By Sally McElroy, Associate Legislative Director, NACo

At this writing, the 106th Congress continues its push to adjourn sine die. And, as is typical of this end-of-the-year season, legislation that was thought to be “dead” for the year, suddenly reappears, gets approved, and becomes law. Such is the case with the reauthorization of the Substance Abuse and Mental Health Services Administration (SAMHSA), S. 976.

The Senate passed S. 976 back in November 1999. Efforts to get similar legislation moving on the House side went in fits and starts with momentum never really building to a level to spur action. The availability of a new drug that could replace methadone caused some of the problems, and a tight legislative calendar contributed, as well. A couple of months ago, folks that were following SAMHSA reauthorization generally agreed that it was not going to happen this year. Low and behold, on September 27, H.R. 4365, an omnibus children’s health bill that addressed various, non controversial children’s health programs, sailed through the House by a vote of 394-25 taking S. 976 with it.

Here’s how it happened: During Senate consideration of H.R. 4365, SAMHSA reauthorization (S. 976) was approved as an amendment to the legislation by voice vote. House and Senate leaders then agreed to bypass a formal conference to reconcile the differences between the two versions of H.R. 4365 and instead brought the amended version back to the House for final approval. The bill has now been sent to the president for signature.

This is just one example of many similar scenarios that can take hold of outstanding issues at this time of year in Congress when Members of Congress look for “any train that is leaving the station”. Year-end spending measures often become vehicles for otherwise stranded legislation, as well, causing staffers all over Capitol Hill and throughout Washington to man their “bat phones” until Congress officially adjourns. Like the old adage goes: It ain’t over ‘til it’s over.

Calendar of Events

Fall / Winter, 2000

November 8-11: National Association for Rights Protection and Advocacy (NARPA). **19th Annual Conference.** Sacramento, CA. Contact Colleen Fry at NARPA. (Source: Advocacy Unlimited web site).

November 9-10: Open Minds. **Strategic Positioning Institute: Navigating Turbulent Times - Preparing for Managed Care Competition.** Orlando, FL. Contact Open Minds. (Source: Open Minds web site).

November 9-12: Coalition for Juvenile Justice, **Fall Training Conference and Board Meeting: Treating the Mental Health Needs of Young Offenders.** Crowne Plaza Hotel, Tampa, FL. Call: Candice Buchanan; (202) 467-0864x8.

November 11-13: **First Annual Conference on Mental Health Care for Hispanics: Challenges for the New Millennium.** Santa Fe, NM. Call: (213) 538-0225.

November 12-16: American Public Health Association. **28th Annual Meeting: Eliminating Health Disparities.** Boston, MA. Call: (202) 777-2478.

November 15-19: International Society for Traumatic Stress Studies. **16th Annual Conference: Public Health Perspectives on Trauma Treatment and Research – A Continuum of Care from Primary Prevention to Clinical Services.** San Antonio, TX. Call: (847) 480-9028.

November 30-December 2: Federation of Families for Children's Mental Health. **12th Annual Conference.** Renaissance Hotel, Washington, DC. Contact: www.bcfamily.com

December 1: Open Minds. **Information Technology Institute: How to Leverage Your Technology Investment.** Santa Monica, CA. Contact Vicki Arentz at 877-350-6463.

December 1-3: Zero to Three. **National Training Institute.** Washington, DC. Call 703-271-1296. (source: NCJRS web site).

December 3-6: National Association of State Mental Health Program Directors (NASMHPD) **Commissioners Winter 2000 Meeting/NASMHPD Forensic Division 2000 Annual Conference.** Chandler, AZ. Call: (703) 739-9333.

December 6-8: World Federation for Mental Health. **First Biennial International Conference on Prevention/Promotion: The Promotion of Mental Health and Prevention of Mental and Behavioral Disorders.** Atlanta. Call: (604) 681-5226.

December 11-13: North Carolina Council of Community Programs. **Annual Conference and Exhibition: "Driving for the Leader Board"**, Pinehurst Resort and County Club, Pinehurst, NC. Contact: (919) 755-0680.



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