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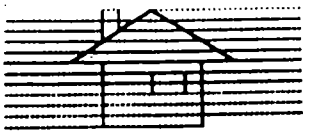
NATIONAL COALITION FOR THE HOMELESS

DAVID BERISS
HEALTH POLICY ANALYST

1612 K Street, NW #1004
Washington, DC 20006
Phone: 202/775-1322
Fax:202/775-1316
Email: nch@ari.net
Homepage: http://nch.ari.net



National Coalition for the Homeless

Projects for Assistance in Transition from Homelessness (PATH)

Congress should work to meet the needs of people with severe mental illness who become homeless by funding the Projects for Assistance in Transition from Homelessness (PATH) program at a level of $40 million for FY97.

Congress should ensure the continued existence of the program by passing S. 1180, the Substance Abuse and Mental Health Services Administration (SAMHSA) Reauthorization, Flexibility Enhancement and Consolidation Act of 1995.

The Program

The Projects for Assistance in Transition from Homelessness (PATH) grant program was authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. It is administered by the Center for Mental Health Services under SAMHSA. The PATH program was created to help states and territories provide community-based services for people with serious mental illness who are homeless or at imminent risk of becoming homeless.

PATH programs have proven very successful in reaching out to people who have been alienated from mainstream systems of care. PATH services eliminate the "revolving door" of episodic inpatient and outpatient hospital care. Multi-disciplinary teams address client needs within a continuum of services, providing needed stabilization so that mental illnesses and co-occurring substance abuse and medical issues can be addressed. Assistance is provided to enhance access to housing, rehabilitation and training and other needed supports. Without targeted funding for this purpose current providers will not be able to accommodate the particular needs of mentally ill homeless people, who will be left to wander the streets untreated and risk being hospitalized at the most expensive point of care.

Federal, state and local PATH funds are often the only resources available to communities to support the types of services that are necessary for homeless people with severe mental illnesses: **outreach** to those outside the mental health system, **engagement** in treatment and services and **transition** to mainstream mental health treatment, housing and support services. **PATH works - it meets a need no other program meets and, in so doing, reflects a wise use of scarce resources.**

Appropriations

Until 1996, from $29.4 - 33 million was appropriated annually for PATH. For every $3 dollars of federal funds provided, a $1 match in non-federal funds is required. Services provided by PATH dollars include outreach, screening and diagnostic treatment, rehabilitation, alcohol and drug treatment, staff training, case management, supportive services in residential settings and assistance in gaining housing. Not more than four percent of a state's allocation can be used for administrative expenses.

In 1994, 395 agencies reported providing one or more PATH-funded services to 127,231 people, using $29 million in Federal funds and an additional $20 million in State and local matching funds. On average, PATH funds represent more than 25% of the funds used by local provider agencies to

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Email: nch@ari.net • Homepage: http://nch.ari.net • Handsnet: HN0055

serve homeless individuals with severe mental illnesses. Without these funds, vulnerable individuals would not be connected to needed services.

- In a recent letter from HHS Assistant Secretary John J. Callahan, the Administration has professed its strong support for programs that serve homeless persons with mental illness. However, the President's proposed FY 1997 budget will effectively end the PATH program by consolidating it within the former Mental Health Block Grants (now called Performance Partnership Grants) with no additional funding. **We urge you to contact Assistant Secretary Callahan and let him know that the administration should show its support for services to homeless people with mental illnesses by funding those services. Secretary Callahan can be reached at 202/690-6396.**

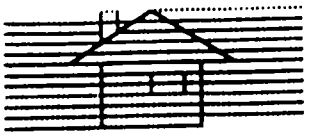
- Congress should be encouraged to appropriate $40 million for the PATH program for FY97. This increase of $11 million over FY95 funding (and $20 million over FY96) would go a long way to addressing the rapidly increasing - and currently unmet - needs of homeless Americans with mental illnesses.

Reauthorization

The Substance Abuse and Mental Health Services Administration (SAMHSA), which administers the PATH program, is subject to reauthorization this year. S. 1180, the SAMHSA Reauthorization, Flexibility Enhancement and Consolidation Act of 1995, sponsored by Senator Kassebaum, has been voted out of committee and currently awaits action by the Senate. In the legislation's current form, PATH has been preserved as a distinct funding stream. There does not seem to be a great deal of enthusiasm for the SAMHSA reauthorization at this time and the bill may not come up for a vote in either house this year. This means that SAMHSA's continued existence would depend entirely on the appropriations process and on the willingness of Congress to continue to fund unauthorized programs.

- The Administration and the House Appropriations Committee have tried to consolidate PATH within the Mental Health Block Grants, which primarily fund Community Health Centers. Because CMHCs have not historically targeted funding to activities for mentally-ill homeless people, **it is likely that any effort to incorporate PATH within Mental Health Block Grants will substantially reduce resources available to PATH programs.**

- Homeless people with mental illnesses are among the most vulnerable of all Americans. A recent survey of 29 cities conducted by the U.S. Conference of Mayors found that 23% of homeless persons had a serious mental illness. Mental illness and the lack of needed services was identified by 16 of the 29 cities as a main cause of homelessness. **Failure to provide targeted PATH funds to the states places thousands of people at risk of losing access to needed services. Reauthorization within S. 1180 will make future targeted funding much more likely.**



National Coalition for the Homeless

May 30, 1996

Mark Mioduski
Minority Staff Director
House Appropriations Subcommittee on
Labor, Health and Human Services and Education
United Stated House of Representatives
Washington, DC 20515

Dear Mr. Mioduski,

Thank you for agreeing to meet with Barbara Duffield and myself in order to discuss fiscal year 1997 appropriations for programs that serve homeless people within the jurisdiction of your subcommittee.

As you mentioned, it is likely that the majority will again attempt to consolidate the funding for the Projects for Assistance in Transition from Homelessness (PATH) program within the mental health block grant this year. Yet state mental health directors - and the Community Mental Health Centers the block grant mostly serves - do not have a history of reaching out to homeless people with severe mental illnesses. Furthermore, if no funding for PATH services is added to the block grant, it seems unlikely that the states would be able to provide those services. Clearly, it is important that Congress continue to target funding to services for homeless people with severe mental illness.

Should consolidation occur, it will be important that Congress indicate its belief that funding in the block grant go to support for PATH programs and services. As you requested, I am including report language that you may find useful.

> While the bill does not provide separate funding for grants to states for the Projects for Assistance in Transition from Homelessness (PATH) program, the Committee notes that all activities currently funded under the PATH program may also be funded under the mental health block grant. The Committee recognizes that meeting the needs of homeless people with severe mental illnesses requires special skills and training and that local PATH providers are uniquely qualified to carry out this work. States governments have also generally recognized this expertise by providing generous grants to match Federal PATH dollars. In order to guarantee that these efforts continue, the Committee recommends that $40,000,000 of the funds appropriated for the Mental Health Block Grant be set aside to be distributed to the states in order to provide services to homeless persons with severe mental illness.
>
> PATH is a critical program which provides outreach, mental health and case management services and other assistance to persons who are homeless and have serious mental illnesses. The PATH program makes a significant difference in the

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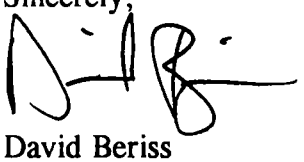
lives of homeless persons with mental illnesses. PATH services eliminate the "revolving door" of episodic inpatient and outpatient hospital care. Multi-disciplinary teams address client needs within a continuum of services, providing needed stabilization so that mental illnesses and co-occurring substance abuse and medical issues can be addressed. Assistance is provided to enhance access to housing, rehabilitation and training, and other needed supports, assisting homeless people in returning to secure and stable lives.

Let me know if we can be of assistance in any other way.

Sincerely,



David Beriss

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

FEB 27 1996

Barbara Knecht
President
Board of Directors
Care for the Homeless
357 W. 55th Street Apt. 4L
New York, NY 10019

Dear Mr. Knecht:

I want to acknowledge the more than 40 letters which I've received from the board and staff of your organization, writing in support of Federal programs for mentally ill homeless persons.

The Administration's budget proposal for fiscal year 1997 is in its final development and is scheduled to be released in mid-March. However, I can assure you that the Administration is committed to continuing its strong support for programs that service the mentally ill homeless populations (e.g., PATH and Health Care for the Homeless).

I appreciate the work of your agency and in hearing the concerns of its staff. I trust that your expressions of need for the homeless are also being conveyed to your congressional and state representatives, whose efforts are crucial in ensuring that such funds are ultimately provided.

Please share this message with your colleagues who took the time to write us.

Sincerely,

John J. Callahan

John J. Callahan
Assistant Secretary for
Management and Budget

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To JOHN LOZIER	From SUSAN NEIBACHER	
Co./Dept.	Co.	
Phone #	Phone # (212) 366-4459	
Fax # (615) 226-1656	Fax #	

National Coalition for the Homeless

ACTION ALERT

THOUSANDS TO BE CUT FROM SSI AND SSDI DISABILITY ROLLS, PLACED ON A SHORT PATH TO HOMELESSNESS

On March 29, 1996, President Clinton signed into law legislation (P.L. 104-121) that would deny SSI and SSDI disability benefits and, by extension, access to Medicaid, to people whose addictions are considered to be a "contributing factor material to" the determination of their disability status. More than 200,000 people who are currently on SSI or SSDI receive their benefits due to a disability determination linked to drug addiction or alcoholism (DAA). All of these people are liable to have their benefits terminated on January 1, 1997. Furthermore, as of March 29, no new beneficiaries for whom addictions are material to their disability will be added to the rolls.

While many current beneficiaries can be reclassified as disabled through conditions not related to addictions, the Social Security Administration believes that **at least 40,000 people are likely to be eliminated from the rolls due to these changes.** Starting in 1997, the Congressional Budget Office estimates that as many as 50,000 people per year will be prevented from receiving these benefits due to classification as DAA.

SSI and SSDI benefits are often the only resources available for individuals to access housing and treatment, both of which are fundamental to recovering from drug addiction and alcoholism. Furthermore, they provide needed access to health care through Medicaid. Changes in the disability definitions are likely to result in 40,000 more Americans becoming homeless beginning in 1997, and in many thousands more becoming homeless over the next few years as people are found to be ineligible for SSI and SSDI. **Without housing and treatment, these individuals will be highly vulnerable to renewed substance abuse and personal suffering. This will also lead to increased pressure on homeless service providers and greater costs to the indigent medical care system. IT IS IMPORTANT THAT YOU ACT NOW!**

- **Help Prevent Your Clients From Losing Eligibility.** Persons (and their Representative Payees) currently receiving benefits due to DAA must be notified by SSA no later than June 28, 1996 that their benefits will end on January 1, 1997. If they reapply by July 28, 1996, SSA must make a new medical determination no later than January 1, 1997. If the client is found to have a non-DAA condition, benefits will continue. Remind your clients and their representative payees that they should be receiving notice of these changes in the mail. **Placing notices with dates, contacts and addresses in shelters, soup kitchens and clinics will help reach people who may not regularly receive or read their mail.**

- **Contact your local Social Security Office and state Disability Determination Service to determine what steps you can take to facilitate the reapplication process.** You may be able to determine in advance who is liable to be terminated, allowing those clients to begin reapplication preparations. You may also be able to collect application materials and help your clients prepare them, thus expediting the process. The National Coalition for the Homeless will serve as a clearing house for information related to discussions with local SSA and DDS offices. Please contact David Beriss at 202/775-1322 with your experiences or if you would like to hear about other approaches.

- **Prepare other local service providers to help prevent people from losing their benefits.** Anyone whose clients may receive benefits due to addictions, as well as

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medical practitioners who may perform disability evaluations, should be provided with training concerning these changes. The Coalition on Homelessness in San Francisco has begun training providers and can provide ideas and materials if you are interested in organizing such training. Contact Jennifer Freidenbach at 415/346-9693.

Congress' action in this situation was based neither on solid data nor on a well-thought out approach to helping vulnerable Americans address their addictions or overcome their disabilities. $50 million was added to the Substance Abuse Block Grant in this legislation, but this is hardly enough to significantly impact the problem. In fact, these additional funds are not even targeted to current or former SSI or SSDI recipients, housed or homeless. Currently, there are no federal funds targeted to services for homeless persons with substance abuse disorders. **However, there are steps you can take to change this situation.**

- **Let members of Congress and the Administration know that this change will result in a significant increase in homelessness.** Health problems will also worsen and health costs for the medically indigent - borne by states and local governments - can be expected to rise, with increased use of emergency rooms and detoxification facilities. Furthermore, an additional $50 million does not begin to address the need for treatment resources, especially since there are an estimated 1 million Americans currently on waiting lists for treatment. **If Congress and the Administration are serious about addressing substance abuse, they should substantially increase resources available for treatment, targeting a significant portion to people excluded from SSI and SSDI.** Members of Congress can be reached at 202/224-3121. Carol Rasco, head of the President's Domestic Policy Council, can be reached at 202/456-1414.

- The Substance Abuse Prevention and Treatment Block Grant is the main source of federal substance abuse treatment funds. There are currently no set-asides within this grant for outreach to or treatment services for homeless people. However, you may be able to work within your state to target some of these funds to the needs of homeless people. **Contact your state Alcohol and Drug Abuse Director and Governor and alert them to the impact these changes in SSI and SSDI will have on homelessness. Remind them that housing and treatment play essential roles in helping people control their addictions.** If you do not know who your state alcohol and drug abuse director is, please contact David Beriss at the National Coalition for the Homeless, at 202/775-1322.

- The increase in homelessness, in substance abuse on the streets and begging will come at a high political cost for local elected officials. **Your governor, mayor, city council members, police chief and public health officials may be enlisted as allies in working to make sure more resources are made available to prevent homelessness among people with substance abuse disorders.** We will need to build strong local coalitions if we are to motivate Congress to devote resources to addressing the problem it has created. Help educate people: **Treatment works and housing is the first form of treatment.**

For further information, please contact David Beriss at the National Coalition for the Homeless, (202) 775-1322, email: nch@ari.net.

Health Care for the Homeless
Federal Policy Issues - June 1996

Health Care for the Homeless projects provide accessible and comprehensive health services to homeless persons. Offering an integrated model of care, HCH projects improve the quality of the lives of homeless persons through primary and preventive health care, outreach, mental health and addictions services, case management, transportation and translation services - and assistance in securing housing and an income.

Initiated by the Robert Wood Johnson Foundation and the Pew Charitable Trusts in 1985, Health Care for the Homeless became a Federal program in 1987. Today, the U.S. Public Health Services' Bureau of Primary Health Care funds 123 Health Care for the Homeless projects in 48 States and the District of Columbia. These public and private nonprofit agencies served 450,000 homeless men, women, and children in 1995.

The turbulent health care environment and dramatic declines in public support directed to indigent and disabled populations increase the importance of **Health Care for the Homeless** as a program targeted to people who are homeless. Maintaining these vital health services requires the following policies:

Guaranteeing the Continuation of the National Health Care for the Homeless Program:

- **Reauthorization of The National Health Care for the Homeless Program** - A version of S.1044, the Consolidated Health Centers Reauthorization Act, or its equivalent should be adopted to assure stability for the national Health Care for the Homeless Program. The proposed guarantee of three year targeted funding for HCH and migrant health programs should be extended to five years.

- **Appropriation for the National Health Care for the Homeless Program** - Congress should provide at least **$72 million** for the Health Care for the Homeless Program's portion of the consolidated health centers appropriation in FY97, enabling these programs to keep pace with inflation.

Strengthening mental health services for homeless persons:

PATH (Projects for Assistance in the Transition from Homelessness) is the sole Federal program specifically funding mental health services for hundreds of thousands of Americans with mental illnesses on our streets. **We seek an FY97 appropriation of $40 million, enabling 175,000 persons to be served.**

Securing accessible addictions treatment for homeless persons:

Research has demonstrated that services which address the specific needs of homeless persons with addictions can be effective. **The Federal Substance Abuse Prevention and Treatment Block Grant should explicitly require that the needs of homeless persons be addressed by States and local providers, and FY97 appropriations should accurately reflect the complexity of treating vulnerable persons with addictions.**

Meaningful Medicaid reform:

Until health insurance is universally available by means of a single payer system, any reform of the Federal Medicaid program should maintain the legally-enforceable entitlement to health care for indigent, disabled, and elderly Americans. The participation of Health Care for the Homeless projects and other indigent care providers in Medicaid is vital if Medicaid is to comprise an effective safety net.

For further information, please contact:
The National Health Care for the Homeless Council, 615/226-2292
The National Coalition for the Homeless, 202/775-1322, or
The National Association of Community Health Centers, 202/659-8008

Reauthorization of the National Health Care for the Homeless Program - June 1996

We urge Majority Leader Dole and the Senate to adopt S.1044 or equivalent legislation. The guarantee of proportional funding for homeless health care within S.1044 should be extended to 5 years.

We further urge the House Commerce Committee to consider legislation which reauthorizes the Health Care for the Homeless Program for at least five years, and which guarantees funding targeted to homeless health care projects for this period.

The Federally-funded Health Care for the Homeless Program was created as Section 340 of the Public Health Services Act by the Stewart B. McKinney Act of 1987. This legislation built on the experience of a Robert Wood Johnson Foundation/Pew Charitable Trusts endeavor establishing Health Care for the Homeless projects in 19 cities across the United States. Evaluation of these projects demonstrated that health care programs specifically targeted to homeless persons could effectively reach this vulnerable and seriously ill population.

The past ten years have further demonstrated the significance of targeted funding for health care services to homeless persons. Their poor health status contributes to their homelessness; their homelessness causes other health problems, while exacerbating existing conditions. Additionally, homelessness dramatically complicates treatment. An **integrated model of care**, coordinating a comprehensive set of services, best addresses the health needs of homeless persons. This model includes not only primary health services, but outreach, mental health and addictions services, and case management, as well as attention to meeting clients' needs in the areas of employment and educational services, child care, transportation, dental care, translation services, and affordable housing.

Absent a Health Care for the Homeless program, indigent care providers might offer some level of primary care to homeless persons. Indigent care systems are, however, overwhelmed by burgeoning demand associated with rising poverty rates accompanied by increasing numbers of uninsured Americans. The fragile indigent care infrastructure - including rural and inner city hospitals, public clinics, and solo practitioners - is also threatened by the consolidation of health services and the growth of for-profit managed care companies (which rarely have the experience, expertise, or will to serve especially vulnerable populations).

Thus, a national Health Care for the Homeless Program remains indispensable. The authorization for this program expired on September 30, 1995. Legislation to assure its continued existence has been adopted by the Senate Labor and Human Resources Committee [S.1044, the Consolidated Health Centers Reauthorization Act], but has not been brought to the Senate floor. In the House, Congressman Bill Richardson (D-NM) has introduced a reauthorization measure [H.R.3081], as have Congressmen John Dingell (D-MI) and Henry Waxman (D-CA) [H.R.2206]; neither bill has been considered by the Commerce Committee.

S.1044 consolidates the health center programs currently operating as Sections 329 (Migrant Health), 330 (Community Health), 340 (Health Care for the Homeless), and 340A (Health Centers in Public Housing) under a single Section of the Public Health Services Act. It authorizes funding for five years, but maintains the existing proportionate allocation among the previously distinct Sections for only three years. During the fourth and fifth years of the authorization, the Secretary of Health and Human Services is required to assure that funding is distributed appropriately to meet the needs of vulnerable populations; however, projects which specifically address the health needs of homeless persons would not be guaranteed funding. While we support the consolidation's goal of reducing administrative costs, the specific and complex health needs of homeless persons require the availability of the existing homeless health care infrastructure; legislation should provide this guarantee.

Appropriation for the National Health Care for the Homeless Program - June 1996

We urge the President and Congress to fund the National Health Care for the Homeless Program's portion of the consolidated health centers appropriation in FY97 at least at $72 million - equivalent to the FY95 appropriation ($65.4 million) plus inflation of 5% per year. In FY97 the consolidated health centers appropriation should total at least $832 million.

Hundreds of thousands of homeless Americans need accessible, appropriate health care services. Health Care for the Homeless projects across the U.S. depend on Federal funds, combined with the substantial dollars which they leverage, to help meet this need. But these Federal funds are not at all secure.

The Omnibus Appropriations and Rescission Act adopted on 4/25/96 concluded the Federal appropriations process for this fiscal year. For FY96 the National Health Care for the Homeless Program received a level of funding equivalent to the FY95 amount of $65.4 million. This appropriation is part of a larger consolidated health centers appropriation of $759,523,000, which includes monies for community health centers, migrant health centers, health centers in public housing, and Native Hawaiian health centers.

The $65.4 million in Federal contributions supports 123 Health Care for the Homeless projects. These community-based primary care providers reached 450,000 different homeless people in 1995, who are generally uninsured persons with multiple health and social problems. At current levels of funding, HCH projects currently are able to assist only one-fifth of those living on the streets or in shelters. This publicly-supported primary care infrastructure becomes increasingly more important as the numbers of Americans who are uninsured and homeless rises. And Federal Health Care for the Homeless dollars are an essential element of this infrastructure: combined with at least $32.7 million in matching local dollars, Federal funds produced nearly $100 million for these crucial targeted health services.

The rapid consolidation within the health care industry and the movement to managed care for Medicaid participants is increasing the pressure on the existing indigent care infrastructure. Economic pressures on inner city hospitals and independent rural practitioners reduce the availability of care for the uninsured. The conversion of not-for-profit health facilities to for-profit status may increase corporate contributions to public treasuries, but diminishes the provision of uncompensated care. These tax dollars must be directed toward the 41 million Americans without health insurance, and particularly to the most vulnerable among us - homeless persons.

Without the Federal funds, many HCH projects would be forced to shut their doors, exacerbating the effects of untreated health problems - both for homeless individuals and for the general public. The important TB and HIV management and prevention which HCH projects provide would be lost; remaining public health providers would become even more crowded; persons with mental illness and addictions would remain unserved on our streets; homeless children would go without immunizations; homeless women would have no access to prenatal care; and emergency room use - the most expensive point of care - would increase. As a consequence, our communities' health would decline and health care costs for all would escalate.

As homelessness increases and the complexity of the health problems of homeless persons mounts, additional dollars are required to meet these needs. An adequate Health Care for the Homeless Program is an investment in an effective and accessible health care infrastructure, an investment with substantial returns for homeless individuals and families, as well as for the health of our communities.

Strengthening Mental Health Services For Homeless Persons
Health Care for the Homeless - June 1996

In FY97 Congress and the President should increase funding for PATH to $40,000,000. This will permit the provision of mental health services to 175,000 homeless persons.

ACCESS, a demonstration project of the Federal Center for Mental Health Services, should receive an FY97 appropriation of at least $18.5 million. This will maintain valuable services to homeless persons with mental illnesses at 18 sites across the U.S.

The eleven years of experience of the Health Care for the Homeless program demonstrate that homelessness can best be addressed if a comprehensive set of services is accessible to our clients. These include not only primary health services, but mental health services as well.

A significant proportion of homeless persons suffer from mental illnesses; **Outcasts on Main Street: The Report of the Federal Task Force on Homelessness and Severe Mental Illness** suggests that, on any given night, 1/3 of the single adults experiencing homelessness have a serious mental illness. Unfortunately, our existing mental health service system is largely inaccessible to homeless persons. Few public or private mental health providers have the infrastructure or expertise to meet the needs of these very vulnerable persons.

Persons with serious and persistent mental illnesses who are living on the streets frequently cycle through such institutions as courts, jails, emergency rooms, and psychiatric hospitals. Without stabilizing services and appropriate housing, these persons suffer inordinately while imposing significant costs upon the community.

Successfully treating persons with mental illnesses living on our streets requires extensive outreach, flexible appointment schedules, aggressive case management, access to temporary and permanent housing resources, patience, and persistence. Outreach workers may visit a person with serious and persistent mental illness for one year or more before establishing a relationship of trust which enables the client to accept psychiatric services. It is frequently essential to provide food, clothing, showers and other nonmedical services to these persons prior to, or simultaneous with, the provision of medication and therapy. And it is essential to coordinate aggressive mental health services with a range of other health and social services. This model of care can result in long term gains for the client and for the community.

The **PATH** and **ACCESS** programs, which are the sole source of Federal funds targeted toward the mental health needs of homeless persons, enable the provision of these nontraditional services, and should be preserved. **PATH, Projects for Assistance in the Transition from Homelessness**, provides monies in each State to fund local initiatives reaching out to homeless persons with mental illness who cannot access existing services. **PATH** projects assisted 127,231 different persons in 1994. **We recommend increasing the FY97 PATH appropriation to $40 million, in order to serve 175,000 persons.**

ACCESS funds nine research demonstration projects at 18 sites, testing the proposition that only fundamental systemic changes in the organization and provision of mental health and related services can be effective for severely disabled persons. The systemic changes suggested by ACCESS should result in service delivery models proven to be effective and cost-efficient. **In FY97, ACCESS requires $18.5 million to complete both service and evaluation components.**

Securing Accessible Addictions Treatment For Homeless Persons
Health Care for the Homeless - June 1996

We urge the President and Congress to fund alcohol and drug abuse treatment to meet the extraordinary needs of homeless persons, including outreach, treatment, and supportive services such as housing and vocational assistance. Language requiring States to develop their own responses to homelessness and addictions should be incorporated in the Federal Substance Abuse Block Grant.

We call for an evaluation of the actual cost of the short-sighted public policy enshrined in P.L.104-121 (i.e. the recent exclusion of persons with addictions from Federal benefits) and for Federal measures to ameliorate its impact, including outreach to those abandoned by this policy.

An important component of an integrated model of care is the availability of alcohol and drug abuse services which are explicitly responsive to homeless people. A substantial proportion of those living on the streets suffer from addictions to alcohol or drugs. Although all Health Care for the Homeless projects offer addictions services, none have sufficient resources to meet the demand. Further, no other Federal funds are currently targeted to the needs of the hundreds of thousands of homeless Americans who are not assisted by HCH projects. Federally-funded research demonstration projects have proven that homeless persons can benefit from addictions services tailored to their special needs, but existing services are generally not designed to be accessible to persons who live on the streets. And the costs of untreated addictions - to the addicted and to communities - is exorbitant.

It is not enough to decry the scourge of addictions. Data from the University of Chicago and the Rand Corporation demonstrate that each $1 spent for addictions services saves $7 for taxpayers; but we must be committed to invest in accessible treatment.

The demand for adequate addictions treatment is exacerbated by recent changes in federal law. P.L.104-121, the **Contract With America Downpayment Act of 1996**, denies medical insurance and cash assistance to persons whose addictions to alcohol or drugs have "materially contributed" to the finding of disability by the Social Security Administration. Beginning on January 1, 1997, **200,000 to 250,000 vulnerable adults** are in danger of losing their eligibility for SSI, Social Security Disability, and Medicaid.

Only $50 million, or $200 per person per year, has been added to an insufficient Federal Substance Abuse Treatment and Prevention Block Grant to ameliorate the impact of this legislation. Health Care for the Homeless projects, already strained to meet the needs of persons with addictions, will surely be overwhelmed. And the social costs of this policy - increased numbers of vulnerable and desperate addicts and alcoholics living on our streets and begging for assistance - are enormous.

To the detriment of us all, Federal addictions policy continues to serve vulnerable populations inadequately. We call upon the Congress and the President to make an investment in the treatment and services which can assist our clients and improve our communities; to require that States develop their own mechanisms to meet these needs; and to report to the public on the actual costs of policies which exclude persons with addictions from access to treatment, housing, and health care.

Meaningful Medicaid Reform
Health Care for the Homeless - June 1996

Any reform of the Federal Medicaid Program should maintain a legally-enforceable entitlement to health services for indigent, disabled, and elderly Americans.

Payment mechanisms must exist to secure the ability of Health Care for the Homeless projects to adequately serve Medicaid participants.

Services complementing primary care which the HCH model has incorporated - outreach, case management, mental health and addictions services, transportation, and translation services - must be remain reimbursable under new Medicaid rules.

Medicaid is the Federal health insurance program which currently guarantees a set of benefits to eligible persons, as well as payments to specific providers (such as Health Care for the Homeless projects). Medicaid is authorized under Title XIX of the Social Security Act; each State operates its own program under specific Federal regulations. 18.4% of the persons served by HCH programs in 1994 were Medicaid beneficiaries, and this program is an important source of funds to HCH. Additionally, Medicaid provides crucial access to health care services for homeless persons not served by Health Care for the Homeless projects, while functioning as an essential homelessness prevention mechanism.

President Clinton has publicly committed himself to maintaining the historic guarantee of health care to indigent, disabled, and elderly Americans. At the same time, the Federal Health Care Financing Administration has, with his approval, authorized State waivers of every aspect of Federal Medicaid requirements, except the entitlement. The President now faces extraordinary pressure to take the next step and eliminate the entitlement. Several Congressional proposals would transform the Medicaid program into a block grant and eliminate the guarantee that individuals or providers would receive any specific services or payments. The National Governors Association has adopted a well-received Medicaid proposal which could end the guarantee that comprehensive health care will be available to those in need. Most proposals include dramatic reductions in Federal Medicaid spending and limitations on requirements for State spending, presenting an additional threat to the Medicaid program and the indigent health care system which it supports.

It seems inevitable that Medicaid will change dramatically, either through the "thousand cuts" of the waiver process, or by the elimination of Title XIX of the Social Security Act via legislation. Yet Medicaid is crucial to assuring access to health services for poor and homeless persons. Consequently, Congress should not adopt, and the President should veto, any legislation such as the MediGrant proposal or the resolution adopted by the National Governors Association which ends the Medicaid entitlement and reduces the quality and availability of Medicaid services.

Furthermore, to protect the interests of homeless persons, Medicaid must include mechanisms which assure that Health Care for the Homeless projects and community health centers can adequately serve Medicaid participants. These mechanisms could include maintaining the cost-based reimbursement associated with Federally Qualified Health Center status, adequate risk-adjusted capitation payments for HCH projects which contract for prepaid services with Managed Care Organizations, or a Federally-guaranteed supplemental payment to HCH projects. Services complementing primary care which the HCH model requires - outreach, case management, mental health and addictions services, transportation, and translation services - must be retained as reimbursable services under new Medicaid rules.

Until health insurance is universally available, e.g by means of a national single payer system, a strong Federal Medicaid is an absolutely essential safety net. It must not be weakened.

ESTIMATE OF POTENTIALLY REDUCED NUMBER OF PATH CLIENTS SERVED UNDER FY '96 PATH FUNDING

States	FY '95 PATH Funds (in dollars)	FY '96 PATH Funds (in dollars)	% Cut in Funds from FY '95 to FY '96	# of PATH Clients served in FY '95	Estimate of Potentially Reduced # of PATH Clients Served in FY '96
Alabama	300000	300000	0	1555	0
Alaska	300000	300000	0	215	0
Arizona	386000	300000	22	1048	231
Arkansas	300000	300000	0	836	0
California	3705000	1721000	54	15855	8562
Colorado	346000	300000	13	1522	198
Connecticut	357000	300000	16	1593	255
Delaware	300000	300000	0	273	0
Dist of Col.	300000	300000	0	39	0
Florida	1481000	688000	54	2346	1267
Georgia	474000	300000	37	552	204
Hawaii	300000	300000	0	620	0
Idaho	300000	300000	0	487	0
Illinois	1233000	573000	54	1426	770
Indiana	392000	300000	23	1651	380
Iowa	300000	300000	0	788	0
Kansas	300000	300000	0	821	0
Kentucky	300000	300000	0	428	0
Louisiana	324000	300000	7	1528	107
Maine	300000	300000	0	869	0
Maryland	521000	300000	42	2079	873
Massachusetts	688000	320000	54	2276	1229
Michigan	846000	393000	54	1975	1067

States	FY '95 PATH Funds	FY '96 PATH Funds	% Cut in Funds	# of Clients Served in FY '95	Estimate of Potentially Reduced # of PATH Clients Served in FY '96
Minnesota	345000	300000	13	5293	688
Mississippi	300000	300000	0	197	0
Missouri	405000	300000	26	4148	1078
Montana	300000	300000	0	1472	0
Nebraska	300000	300000	0	621	0
Nevada	300000	300000	0	797	0
New Hampshire	300000	300000	0	983	0
New Jersey	964000	448000	54	5656	3054
New Mexico	300000	300000	0	280	0
New York	2054000	954000	54	9777	5280
North Carolina	366000	300000	18	868	156
North Dakota	300000	300000	0	835	0
Ohio	968000	450000	54	3909	2111
Oklahoma	300000	300000	0	833	0
Oregon	300000	300000	0	748	0
Pennsylvania	1049000	487000	54	6145	3318
Rhode Island	300000	300000	0	775	0
South Carolina	300000	300000	0	3455	0
South Dakota	300000	300000	0	656	0
Tennessee	323000	300000	8	2056	164
Texas	1654000	768000	54	7527	4065
Utah	300000	300000	0	1068	0
Vermont	300000	300000	0	1999	0
Virginia	557000	300000	46	2816	1295

States	FY '95 PATH Funds	FY '96 PATH Funds	% Cut in Funds	# of Clients Served in FY '95	Estimate of Potentially Reduced # of PATH Clients Served in FY '96
Washington	468000	300000	36	2143	771
West Virginia	300000	300000	0	1823	0
Wisconsin	359000	300000	16	2907	465
Wyoming	300000	300000	0	96	0
Puerto Rico	309000	300000	3	3982	119
Guam	50000	50000	0	60	0
Virgin Islands	50000	50000	0	34	0
Am Samoa	50000	50000	0	58	0
N. Mariana Isl.	50000	50000	0	41	0
TOTAL				114840	37707

National Coalition for the Homeless

The PATH Program

The Projects for Assistance in Transition from Homelessness (PATH) formula grant program was authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990 (PL 101-645). It is administered by the Center for Mental Health Services under SAMHSA. The PATH program was created to help all states and territories provide community-based services for people with serious mental illness who are homeless or at imminent risk of becoming homeless.

PATH has been appropriated from $29.4 - 33 million annually since 1991. For every $3 dollars of federal funds provided, a $1 match in non-federal funds is required. Services provided by PATH dollars include outreach, screening and diagnostic treatment, rehabilitation, alcohol and drug treatment, staff training, case management, supportive services in residential settings and assistance in gaining housing. Not more than four percent of state's allocation can be used for administrative expenses.

Each state is required to report annually on its use of PATH funds. That data is compiled and evaluated by the Center for Mental Health Services and used for program planning. The latest data available is from FY 94. The federal appropriation was $29.5 million. States matched with $20 million, far exceeding their required one-fourth. In FY 94 over 127,000 people received PATH-supported services.

PATH works. It acknowledges that mainstream mental health services are inadequately equipped to treat this most disenfranchised segment of our population. The key to rehabilitating seriously mentally ill homeless people is to win their trust and then to engage them in an integrated support system. They do not and cannot be expected to seek out care. As Dr. E. Fuller Torrey testified before the Labor Committee on July 27, severe mental illnesses--brain diseases--impair cognition. The severely mentally ill homeless are easily alienated from mainstream systems of care and require special outreach and careful casework management.

Homeless people cannot be reached by mail or telephone. They cannot make appointments consistently because they spend a good part of every day waiting in line for food and shelter. Many don't have access to transportation. When these problems are compounded by mental illness they become far less engaged or able to meet their needs. Severely mentally ill homeless people are the lowest priority on most people's lists. They are the "bums." When given the choice, charitable donations go to children and families, and mental health facilities serve easier to reach populations. A PATH provider in Las Vegas says "no one else can work with this population. Our mental health system won't work with them. Our clients are afraid of mainstream mental health and we have to accept that. If we lost our PATH funds over 200 more people would be on the streets. We get our clients Social Security. We continue to work with them. You've got to meet their basic needs.

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Mental health is not set up for that. PATH providers know how to reach these people. We are more laid back. We can get our clients off the street in a day."

A PATH grantee in Des Moines reports that his agency, the Broadlawns Medical Outreach Project of Polk County Health Services, Inc. is the only agency in Des Moines allowed to conduct outreach. These people die during Iowa winters. This Polk county social worker reported that one and a half hours after he had learned that PATH had been zero-funded in the 1996 House appropriations bill, he received a call from the district office of the Des Moine's congressman asking what to do with the homeless people appearing at the door. They had been thrown out of their shelter and the shelter advised the congressman's staffer to call Broadlawns. The social worker claims that loss of PATH funds will mean many more people in jail and on the street and many more using drugs.

A PATH grantee from Buffalo wrote to us in August, "...we have found quite a few people who are so very grossly psychotic that they are unable to orient themselves enough to remember to TAKE medication and are deemed basically unacceptable by community residences. These are the true, homeless mentally ill." She reports that one client, missing from her facility for a year and a half, showed up at her facility "sunburned, wide-eyed, decompensated, frightened, with severe ataxia (loss of muscle coordination), a new speech impediment and a very stiff gait." He'd been hit by a car which broke both his legs in two places, and left on the road unconscious. He was hospitalized, but misdiagnosed, and treated with the wrong psychotropic drugs. Then he was committed to a nursing home where he was diagnosed as mentally retarded. He eventually became combative with staff, so he was put on a bus back to Buffalo.

Her PATH funds allowed her to secure her client temporary housing, reconnect him to Social Security and Food Stamps and be seen by an on-site physician who gave him the proper prescriptions. All this for a fraction of the cost of emergency room care or incarceration. Because this provider is equipped to treat severely mentally ill homeless people, she is much more likely to rehabilitate them and take them off the streets.

The director of the Community Advocacy and Support Alliance in St. Louis, Missouri explains that PATH funding has allowed his agency to fund a Shelter Outreach Team, which goes to shelters in the St. Louis area to locate mentally ill clients and bring them in for voluntary treatment. He says that over one-third of those referred become engaged with community services. His is the only outreach team in St. Louis, and without PATH funds, he claims outreach would not take place. Asked if PATH funding were eliminated would private donations pick up the tab, he replied, "not a chance." Asked if the state would fund outreach he reported that the State Department of Mental Health has been cutting funding for years. Finally, when asked about mental health block grants, his response was "this is not a priority. This group has no political or economic clout." Community mental health centers can treat many more patients much more efficiently with measurable results when they don't have homeless patients. Under a community mental health block grant the homeless would be left untreated and their numbers would multiply.

The Bazelon Center for Mental Health Law writes that "the experiences of homeless people and more than a decade of treatment research support outreach and engagement as the most successful approach in moving people with mental illness out of homelessness." The executive director of the National Health Care for the Homeless Council reports that PATH helps to pay for services which "are generally quite effective and have resulted in long term stabilization for thousands of psychiatrically disabled people."

It is the outreach and case management paid for with PATH funds that allow us to engage our clients in a support system that can provide psychiatric treatment, primary health care, substance abuse treatment, when necessary, vocational training and some housing services.

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SAMHSA
Substance Abuse and Mental Health Services Administration

CMHS
Center for Mental Health Services

Projects for Assistance in Transition from Homelessness

A Summary of Fiscal Year 1994 State Implementation Reports

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ACCESS TO COMMUNITY HEALTH CENTERS BY HOMELESS PERSONS

JUNE GIBBS BROWN
Inspector General

JULY 1996
OEI-07-95-00060

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EXECUTIVE SUMMARY

PURPOSE

To determine the extent that Federally funded community health centers serve homeless people and how such services can be improved.

BACKGROUND

This survey was requested by the Office of the Assistant Secretary for Planning and Evaluation, (ASPE) representing the Secretary of the Department of Health and Human Services as a member of the Federal Interagency Council on the Homeless.

Community health centers (CHCs) are health clinics that provide comprehensive family-oriented preventive and primary health services to medically underserved, disadvantaged populations experiencing financial, geographic, or cultural barriers to care. There are 623 Federally supported centers in the U.S. and its territories which serve over seven million people.

We selected a random sample of 72 urban centers. We then obtained the names and addresses of homeless shelters in each of the their service areas. We did not gather information from centers which received grants under the Health Care for the Homeless Program since these programs are funded to serve the health care needs of homeless persons.

We mailed surveys to the sample of centers and homeless shelters. These surveys focused on barriers on accessing services, outreach services to the shelters, referrals of homeless clients, treatment services, and case management for homeless persons. We received surveys from 50 centers and 98 shelters in 46 cities.

We also conducted on-site visits at 6 cities with 7 CHCs and 16 nearby shelters. At these cities we interviewed center management and the directors of homeless shelters to supplement and clarify information from the surveys.

FINDINGS

Two Thirds of the Community Health Centers Provide Outreach Services for Homeless People

We found that 64 percent (32 of 50) of the CHCs provide outreach services for homeless people. These services include sending staff to homeless shelters, and/or contacting homeless shelters to provide information on services available. However, we found that for 13 of these centers at least one nearby shelter reported that the centers do not send staff to their shelter.

It is possible that in 9 of the 18 cities where centers did not provide outreach services the health care needs of homeless persons might be served because a specific Health Care for the Homeless Program, funded under a Federal Section 340 Public Health Service grant, exists in those cities. However, the remaining nine cities had neither a Health Care for the Homeless Program nor outreach from the local center.

Community Health Centers Provide A Wide Range Of Treatment Services To Homeless People

The CHCs provide a broad range of treatment services such as acute medical examinations and treatment, screening services for tuberculosis, hypertension, sexually transmitted diseases, and preventive services including well child care, immunizations, comprehensive physicals, prenatal monitoring, and dental. They also provide prescription drugs, laboratory, and radiology services.

Nevertheless, The Centers Face Significant Barriers In Providing Services

Sixty-nine percent (34 of 49) of the CHCs reported that barriers existed with homeless persons obtaining services from the center. The most significant barriers are the lack of available transportation, the center's hours of operation, the clients' inability/unwillingness to follow through on a plan of care, unavailability of necessary services in the community, and the transient status of homeless persons. Fourteen percent adapted their treatment or screening protocols to meet the needs of homeless clients.

Some Homeless Shelters Do Not Refer Clients To Nearby Health Centers

Twenty-eight percent (27 of 97) of the shelters reported they did not refer clients to the centers for health care services. The remaining 70 homeless shelters did. Shelter clients used public transportation, shelter bus tokens, or their own transportation to travel to the centers. Others walked, relied on family and friends, or in some cases used an ambulance.

OPPORTUNITIES FOR IMPROVEMENT

The findings in this report reflect a greater potential for Community Health Centers helping homeless people and suggest that better communication between the Health Resources and Services Administration (HRSA) and the centers, and between the centers and homeless shelters could have a positive impact on access to medical services for homeless individuals.

HRSA can pursue improvements in services offered homeless people in the Community Health Center program by building on its existing efforts. This might include:

- Developing and disseminating materials about effective practices.

- Holding workshops and training sessions for community health centers.

- Emphasizing the responsibility to lessen all barriers which diminish the ability to serve homeless persons who present themselves to the clinic (e.g., hours of operation, transportation to the center).

- Encouraging periodic contact between management of the health centers and the shelters.

Community Health Centers themselves should improve communication with homeless shelters. Some ways to accomplish this include:

- Identifying all homeless shelters that exist in their service areas. The city task forces, coalitions, or networks on homelessness are valuable resources.

- Providing, on a routine basis, information to those homeless shelters in their service areas on services available and locations.

- Conducting periodic meetings with homeless shelters to discuss the medical needs situation in their area, the barriers that exist, and means to best address those barriers.

AGENCY COMMENTS AND OIG RESPONSE

We received written comments from both HRSA and ASPE. HRSA concurred with our suggestions and will develop an action plan to implement them. ASPE commented on the importance of the findings, but raised some questions and made recommendations for additional analyses. As they requested, we clarified our use of the terms "homeless" and "outreach." Their suggestions for additional analysis of such topics as referral patterns, service coordination, emergency services, case management, and actions taken to address barriers are important. Unfortunately they are beyond the scope of our study, which was limited primarily to ascertaining whether and to what extent the community health centers funded by the Federal Government were actively involved in serving homeless individuals. Copies of their comments are attached.

INTRODUCTION

PURPOSE

To determine the extent that Federally funded community health centers (CHCs) serve homeless people and how such services can be improved.

BACKGROUND

This survey was requested by the Office of the Assistant Secretary for Planning and Evaluation, (ASPE) representing the Secretary of the Department of Health and Human Services as a member of The Federal Interagency Task Force on the Homeless.

Homeless People

Homeless people are a heterogenous group of men, women and children. They include long term street dwellers, residents of homeless shelters and temporary living quarters, the chronically mentally ill, the economically disadvantaged, single men and women, the physically abused, families with children, as well as runaway and castoff youths.

Homeless individuals have a variety of health care problems, including a high incidence of mental illness and substance abuse/alcohol disorders. In over half of the cases, they are without health insurance to cover medical care for physical and emotional problems.

Community Health Centers

CHCs are health clinics that were first funded by the federal government as part of the "War on Poverty" in the mid-1960's. Originally managed under the Economic Opportunity Act, the neighborhood health center program was transferred to the Public Health Service in the early 1970's. Centers are located in each of the 50 States, the District of Columbia, and the U.S. Territories and Possessions. The authorizing legislation is Section 330 of the Public Health Service Act, Public Law 94-63.

The centers provide comprehensive family-oriented preventive and primary health services to medically underserved, disadvantaged populations experiencing financial, geographic or cultural barriers to care. They tailor services to meet the specific needs of the community and special populations that include homeless persons, people infected with HIV/AIDS, the elderly, and substance abusers.

There are 623 Federally supported CHCs in the United States and its territories. Serving over seven million people, they are a significant component of the health care services industry in this country. An estimated 61 percent of center users are

members of minority groups (27 percent African American, 27 percent Hispanic, and 7 percent other). Also, about 63 percent have incomes under the poverty level and another 22 percent are between 100 and 200 percent of poverty.

To fulfill the provisions of the Public Health Service Act (42 USC 254c), the centers must, either through its staff and supporting resources, or through contracts or cooperative arrangements:

- Serve areas designated as medically underserved;
- Provide basic primary medical care services plus support and facilitating services appropriate for the target population;
- Have a governing board where the majority of the members are users of the centers' services; and
- Adjust the cost of services to the patient's ability to pay.

The support services that supplement basic services include mental health services, dental services, eye examinations and glasses, podiatry services, ambulatory surgical services, health education services (including nutrition education), and other services appropriate to meet the health needs of their medically underserved population.

Medical services are provided to homeless individuals who present themselves to the center for care. Charges for services are based upon income of the patient. As such, homeless individuals are served as are other patients who utilize the center for medical care.

Correspondingly, Health Care for the Homeless Programs (Section 340 of the Act), which were not the subject of this study, receive targeted funds and thus should be more able to conduct outreach and deal with the complex problems of individuals living on the streets and in other nontraditional settings.

METHODOLOGY

Inspection Focus

The inspection focuses on how CHC's can best service the health care needs of homeless persons.

Sample Selection

We used the Bureau of Primary Health Care's 1994 Directory of Primary Care Programs to identify centers which were funded under Section 330 of the Public Health Service Act. We excluded any centers which also received special funding to operate a Health Care for the Homeless Program.

We selected from the universe of 198 urban Section 330 CHCs a random sample of 72 centers. We excluded rural centers because a random telephone survey of 30 rural centers had shown the majority of them do not serve on-the-street homeless persons or do not have homeless shelters in their service areas. From the sampled centers we obtained the names and addresses of 172 homeless shelters in their service areas. In addition to a mail survey sent to sampled centers we conducted on-site visits to 6 cities with 7 centers and 16 shelters. At these cities we interviewed the centers' management and the directors of homeless shelters to supplement and clarify information from the surveys.

We mailed surveys to the sample of centers and homeless shelters. These surveys focused on the following issues with data pertaining to calendar year 1994.

- Outreach services to the shelters
- Treatment services
- Barriers on accessing services
- Referrals of homeless clients

We received completed surveys from 50 centers and 98 shelters located in 46 cities. Eighty-six percent of the them had a corresponding shelter return a survey. While the surveys were comprised of many closed-ended questions, we also used open-ended questions which provided more in-depth information to explain and expand upon close-ended responses.

We summarized and tabulated the self reported responses to all the survey questions. The responses were quantified to determine such issues as the extent of barriers that prevented access to services, the number of CHCs that provide outreach services to homeless shelters, and the quantity and type of referrals for medical and/or financial services.

Due to survey constraints in our study design we did not examine all health center service configurations that provide medical care to homeless people. Therefore, the total extent of arrangements among shelters and service providers to refer to a particular program because of specific capabilities could not be taken into account. This could have been the case for cities in our study which had Health Care for the Homeless Programs, plus an unknown number of those cities where other programs may also serve homeless individuals.

This report is one of two related reports on health care for homeless persons. A companion report will address the extent that community mental health centers serve the homeless population.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

TWO THIRDS OF THE COMMUNITY HEALTH CENTERS PROVIDE OUTREACH SERVICES FOR HOMELESS PEOPLE

Sixty-four percent (32 of 50) of the centers provide outreach services for homeless persons. These centers sent staff to homeless shelters, soup kitchens, and food pantries. They provided information on services available to homeless clients, assessed needs, provided food and clothing, performed medical services, screenings and triage. They send staff to the majority but not all of the shelters in their service areas. However, we found that for 13 of them, at least one nearby homeless shelter reported that the center did not send staff to their shelter. Also, in our sample of 50 centers we found 48 percent (22 of the 46 cities) have Health Care for the Homeless programs funded by a Federal Section 340 grant. This would mean that such a grantee also operated in the city. We are not, however, aware of the proximity of those grantees to all the homeless shelters.

The remaining centers do not contact or send staff to homeless shelters to conduct outreach. It is possible that in 9 of these 18 cities the health care needs of homeless people might be served because a Health Care for the Homeless grantee program exists in those cities. However, the remaining nine cities had neither a grantee nor received outreach from the local CHC.

Shelter staff identified their outreach needs. Following are examples of some of the outreach services which they feel would be important.

> "We are always struggling to help our residents receive needed health care. We would welcome contact from any medical group that can help,"
>
> "Not enough clients are seen due to lack of available physicians' time. There needs to be more medication, casework, aftercare, and outreach to psychiatric patients,"
>
> "Non-emergency transportation should be accessible to shelters for early morning pick-up for sick children to get to the clinic,"
>
> "They only visit our shelter every other week. A lot of times clients have come and gone by the time they make another visit,"
>
> "We need better communication specifically about services they offer and fees required. Evening and Saturday hours would be helpful for the working families who need their services."

COMMUNITY HEALTH CENTERS PROVIDE A WIDE RANGE OF TREATMENT SERVICES TO HOMELESS PEOPLE

The centers provide a broad range of treatment services. The type of services most commonly provided to homeless clients include:

- Acute medical examinations and treatment, e.g. scabies, lacerations, and foot ulcers.
- Screening services for tuberculosis, hypertension, sexually transmitted diseases, and human immunodeficiency virus.
- Preventive services including well child care (Early, Periodic Screening Development and Treatment program), immunizations (adults and children), comprehensive physicals, prenatal monitoring, and dental.

As shown below, a significant number of CHCs also provide other services which are available to any homeless patient.

Number of CHCs	Type of Services
40	Laboratory services
34	Prescription drugs
26	Radiology services
19	Mental health counseling
8	Substance abuse treatment

Thirty-one of them reported the percent of treatments that were associated with emergencies. The responses ranged from 1 to 90 percent, with an overall average of 15 percent of treatments being related to emergencies.

The typical center in our sample operated with a budget of $4.4 million, treating an average of almost 15,000 persons/users annually. There was an average of 264 homeless clients served out of an estimated 500 homeless persons in their service area. Approximately 3 percent of their annual budget goes toward the operating costs for serving homeless clients. In addition, for those centers who reported both the total number of persons served and the total homeless clients served, approximately two percent of the total were homeless.

All centers receive funding from Federal grants, with supporting funds from State and local grants. One-third (34 percent) also rely on foundations and donations. Other sources of revenue include third party payers, like Medicare, Medicaid, and patient payments. Some conduct fund-raising and United Way campaigns as well.

Fifty-eight percent of the CHCs' clients are single adults over age 20, with over half of them having no insurance.

The centers reported that at the time of their first encounter, homeless clients were living in the following locations (in descending order): emergency shelters, family/friends, motels, and on the street.

NEVERTHELESS, THE CENTERS FACE SIGNIFICANT BARRIERS IN PROVIDING SERVICES

While most centers provide services for homeless persons, nevertheless, the centers have reported significant barriers in reaching them. A number of centers were not able to report how many homeless persons they serve. However, the figures we do have document that centers are not reaching all of the homeless population in their service area.

Sixty-nine percent (34 of 49) of the centers reported that barriers exist for homeless people in obtaining services. The most significant barriers (in priority order as reported by CHCs) are:

(1) The lack of available transportation
(2) The center's hours of operation
(3) Transient status of homeless individuals makes it difficult to establish a plan of care (e.g., outreach, transportation)
(4) Clients' inability/unwillingness to follow through on a plan of care
(5) Other necessary services not available in the community (e.g., affordable housing, mental health services)

In general, the shelter responses to barriers paralleled this list. Additional barriers reported by the shelters include the clients' unwillingness to go to the center for services and the client not staying long enough in the shelter.

Many centers indicated that they attempt to address barriers in making services more accessible to homeless clients. The following number reported specific services or procedures implemented to address barriers.

Number of CHCs	Actions to Address Barriers
22	Provide transportation to the center
20	Changed their hours and/or extended the hours of operation
19	Improved availability of telephones
8	Provide services at alternate sites (e.g. an off-site clinic)

Fourteen percent (6 of 44) of the centers adapted their treatment or screening protocols to meet the needs of homeless clients. Some of these efforts include:

- Addressing as many health needs as possible at the initial appointment.

- Adjusting any follow-up plan to consider how the needs of homeless clients will impact treatment or follow-up.

SOME HOMELESS SHELTERS DO NOT REFER CLIENTS TO NEARBY CENTERS

Twenty-eight percent (27 of 97) of the homeless shelters reported they did not refer clients to centers for health care services. Reasons reported (in priority order) include:

(1) They were not aware of the center
(2) They use an existing Health Care for the Homeless program
(3) Clients will not access a center due to long waits for appointments
(4) The center is in a different area of town
(5) Clients will not go there due to safety concerns
(6) The center is not a member of the local homeless coalition
(7) Centers have not been receptive to homeless individuals

The remaining homeless shelters referred their clients to centers. Shelter clients used public transportation, shelter bus tokens, or their own transportation to travel to the center. Others walked, relied on family and friends, or in some cases used an ambulance.

OPPORTUNITIES FOR IMPROVEMENT

The findings in this report reflect a greater potential for CHCs helping homeless people. Better communication between the Health Resources and Services Administration (HRSA) and the centers, and between the centers and homeless shelters could improve access to medical services for homeless individuals. Therefore, we suggest that:

HRSA SHOULD PURSUE IMPROVEMENTS IN SERVICES OFFERED HOMELESS PEOPLE IN THE COMMUNITY HEALTH CENTER PROGRAM BY BUILDING ON ITS EXISTING EFFORTS. Examples include:

- Developing and disseminating materials which outline "best practices" from the Community Health Center program and, as applicable, the Health Care for the Homeless Program to improve outreach and referral techniques to serve homeless persons.

- Holding workshops and training sessions for Community Health Centers as part of the Bureau of Primary Health Care's program presentations.

HRSA SHOULD PROMOTE WIDESPREAD COLLABORATION BETWEEN CHCs AND NEARBY SHELTERS.

HRSA could do this by such activities as:

- Emphasizing the responsibility of CHCs to lessen all barriers which diminish the ability to serve homeless persons who present themselves to the clinic (e.g., hours of operation, transportation to the center).

- Encouraging periodic contact between management of the center and shelters to assess the homeless populations' medical needs, and possible solutions to addressing those needs.

- Ensuring that national associations representing homeless shelters are provided listings of CHCs nationally. This will permit these organizations to further disseminate the information to local homeless shelters.

CHCs SHOULD IMPROVE COMMUNICATION WITH HOMELESS SHELTERS.

Some ways to accomplish this include:

- Identifying all homeless shelters that exist in their service areas. The city task forces, coalitions, or networks on homeless populations are valuable resources.

- Providing, on a routine basis, information to those homeless shelters in their service areas on services available and locations.

- Conducting periodic meetings with homeless shelters to discuss the medical needs situation in their area, the barriers that exist, and means to best address those barriers.

AGENCY COMMENTS AND OIG RESPONSE

We received written comments from both HRSA and ASPE. HRSA concurred with our suggestions and will develop an action plan to implement them. ASPE commented on the importance of the findings, but raised some questions and made recommendations for additional analyses.

One of ASPE's questions relates to the definition of "homeless". We found no uniform or standard definition of this term. For example, some include those individuals who reside in transitional housing while others do not. Similarly, some would include those who are temporarily staying with friends or relatives but who otherwise would be homeless, while others would not consider such individuals as homeless. In preparing our survey we consulted with staff of both HRSA and ASPE and agreed to gather information using a broad definition. We explicitly asked the Community Health Centers to identify the conditions under which their homeless clients lived, including those temporarily staying with friends and relatives. We modified our report to make this clear and have provided staff of HRSA and ASPE with a summary of responses which we received from the centers on this matter.

Similarly, ASPE requested us to include a definition of "outreach" and the types of activities it includes. We modified our report to provide a fuller description of the kinds of outreach activities provided by the centers and needed by the shelters.

ASPE requested analysis of additional topics, such as referral patterns, service coordination, emergency services, case management, and actions taken to address barriers. We agree that these are all very important topics. Unfortunately they are beyond the scope of our study. In our early consultations with both ASPE and HRSA staff we agreed that our review would be limited primarily to ascertaining whether and to what extent the community health centers funded by the Federal Government were actively involved in serving homeless individuals. We also expected to identify issues for further study, such as those described by ASPE in their comments. Nevertheless, even though we did not gather extensive data on the these subjects, our staff are available to provide insights on these or other such topics based on their observations and impressions from their site visits.

The full text of HRSA's and ASPE's comments are attached. We appreciate their advice and assistance in this study.

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

MAY 8 1996

TO: Inspector General, OS, DHHS

FROM: Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report "Access to Community Health Centers by the Homeless" OEI-07-95-00060

This is in response to your March 22, 1996, memorandum requesting comments to the draft report, "Access to Community Health Centers by the Homeless." We concur with the OIG's suggestions that HRSA should: 1) pursue improvements in services offered homeless people in the Community Health Center (CHC) program by building on existing efforts, 2) promote widespread collaboration between CHCs and nearby shelters, and 3) determine how CHCs should improve communication with homeless shelters. HRSA will develop an action plan, including target dates, to implement the suggestions and will take into consideration the examples the OIG offered concerning their implementation.

Additionally, attached is a marked-up copy of the draft report with editorial and margin comments for the OIG's consideration.

John D. Mahoney

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

MAY 10 1996

TO: June Gibbs Brown
Inspector General

FROM: Assistant Secretary for Planning and Evaluation

SUBJECT: Comments on the OIG Draft Report: "Access to Community Health Centers by the Homeless," OEI-07-95-00060

Thank you very much for the opportunity to review the above referenced draft. Knowledge about the extent that Federally funded community health centers (CHCs) serve the homeless and how such services can be improved is highly important. In general, we found the report comprehensive: it addressed outreach services to shelters, treatment services, barriers to accessing services and the referral of homeless clients. The reported barriers to services and reasons given by shelters for not referring clients to centers for health care services is important. We did, however, have some concerns and recommendations.

1. **Definitions:** Absent were definitions of homeless and outreach. Without the definitions, the findings become obfuscated. For example, the report states that over two-thirds of the homeless clients treated were staying in an emergency shelter or *living with family or friends*. We had not included the latter group in our definition of homeless--did the CHCs write this in as an "other" category? The definition of homeless is of critical importance, particularly, as it is used as part of the rationale for excluding rural centers (i.e., the majority of rural centers do not serve "the normal on-the-street homeless.") We are not sure of what is meant by "normal" we surmise that the report is referring to persons who are literally homeless.

   The finding that some centers did not send staff to shelters could be better interpreted if there was a definition of outreach services and the types of activities it included. As it reads now, outreach includes providing information on available services, visiting shelters, having contact with homeless people, non-emergency transportation, and hours of service.

2. **Exclusion of rural centers.** With regard to the probe which led to the exclusion of rural centers, more information about the probe is needed to add clarity and justification for their exclusion. How was the probe conducted? Did it consist of site visits and/or conversations with key informants? We recommend you provide more information on the probe used to exclude rural centers.

3. **Referrals.** The reports cites constraints on the survey design as the reason for not being able to take into account the total extent of referral patterns. If there any data that could shed some light on the types of services to which shelters report making referrals, (and where CHCs rank in relationship to other types of services) please provide them.

4. **Service coordination.** Mentioned in a couple of places is the co-location of Health Care for the Homeless (HCH) programs in the same community. If these data permit, please report on referral activities and other service coordination activities in places where HCH programs are co-located.

5. **Emergency services and case management.** An interesting finding is the reported percentage of emergency services provided to homeless clients. A related question is whether these were in fact "true" emergencies or were persons accessing primary health care through the emergency room. If data are available on the nature of the emergencies, we request that they be reported.

   Additionally, did any of the centers report providing case management services? If so, report the percentage which provide case management services.

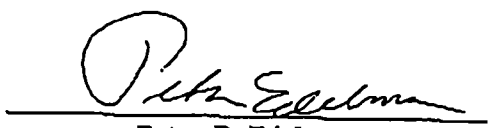
6. **Barriers.** Important findings were presented on the actions taken to address the barriers to service. A fairly common reported action was the "improved availability of telephones." Please clarify what is meant by the action (e.g., were 1-800 numbers or hot lines added or were telephones made available within the communities)?

   If the data permit, please report comments made by respondents on the effects of actions to address barriers (e.g., increased access to services, improved quality in screening, increased service usage, etc.).

   If the data permit, report on the difference in the barriers identified by CHCs and those identified by shelters?

7. **People focused language** (rather than illness and homeless focused). The report consistently refers to homeless persons as "the homeless" and persons with chronic mental illness as "the chronically mentally ill." We recommend you revise the terminologies to read: homeless persons or homeless people, and persons with chronic mental illness.

We hope the comments and recommendations will be useful and look forward to receiving the final report.



Peter B. Edelman

Greg White 5-7791

THE WHITE HOUSE

WASHINGTON

Health Care for Homeless

- idea: smaller programs ⇒

HC for Homeless, Community HCtrs, Migrant HCtrs, HC for Pub Hsg } for 1st 3 yrs, each of 4 activities get same amt

- HHS pleased to have consol'd - bec funds off bl grants

- Senate approved
- House - Dingell
- Appropriators have funded as 1 line

Consol'd: $ still distrib'd by fed'l gov't

Bl Grant: $ to States

PPG: $ to States, but req'd perf measures
- more accessibility

Ted Wright 293-6469

4156-2604

President Clinton's FY 1997 Budget Proposal for Homeless Assistance Programs Compared to FY 1995 and FY 1996

4115 2552 2557

Program	Dept.	FY 1995 Appropriations Oct. 1, 1994– Sept. 30, 1995	FY 1996 Appropriations Oct 1, 1995– Sept. 30, 1996	FY 1997 Clinton Budget Proposal Oct. 1 1996– Sept. 30, 1997	Change from FY 1995	Change from FY 1996
HUD McKinney Act Programs (includes SRO Section 8 Moderate rehabilitation; Supportive Housing; Emergency Shelter Grant; Shelter + Care; Rural Homeless Assistance; Safe Havens)	HUD	$ 1.12 Billion	$ 823 million	$1.12 Billion	0%	+ 36%
Housing Opportunities for People with AIDS (HOPWA)	HUD	$ 186 million	$ 171 million	$ 171 Million	- 8%	0%
Emergency Food and Shelter Program (Administered by FEMA)	FEMA	$ 130 million	$ 100 million	$ 100 million	- 23%	0%
Education for Homeless Children and Youth	Educ.	$ 28.8 million	$23 million	$ 29 million	+ 1%	+ 26%
→ **PATH** (block grants to States for mental health services to homeless people)	HHS	$ 29 million	$20 million	$ 0*	- 100%	- 100%
→ **ACCESS** (demonstration program on how to help homeless people with mental illness)	HHS	$ 21 million	$ 0*	$ 0*	- 100%	0%
→ **Health Care for the Homeless**	HHS	$ 65.4 million	$ 65.4 million**	$ 65.4 million**	0%	0%
Emergency Community Services Homeless Grant Program (set-aside in the Community Services Block Program)	HHS	$ 19 million	$ 0***	$ 0***	- 100%	0%
Runaway and Homeless Youth Program (including drug abuse prevention and transitional living programs)	HHS	$ 68.6 million	$ 57.1 million	$ 68.6 million	0%	+ 20%

* Consolidated into a mental health performance partnership program with no set-aside ← 275 million

** Consolidated into Health Centers Cluster

*** Eligible activity under CSBG, but no set-aside and no additional money.

← Increase of 11 million over FY '96 PATH + ACCESS

10% of State $ can go to Sub. abuse

- Represent Covenant House

CC: Jeremy B
Molly B
Skila Harris
Doug Steiger

EXECUTIVE OFFICE OF THE PRESIDENT

27-Jun-1996 03:03pm

TO: Nancy-Ann E. Min

FROM: Molly Brostrom
Domestic Policy Council

CC: Jeremy D. Benami
CC: Douglas L. Steiger
CC: Skila S. Harris

SUBJECT: RE: PATH program

Thanks Nancy-Ann for responding so quickly. I just wanted to clarify a couple things (I think 2 is really the only outstanding question):

1--We will not oppose PATH as a separate line-item from the MH PPG.

2--Given the SSI changes and the fact that the FY 96 and 97 level of $20 million is below the 95 level of $29 million, is there any chance of our advocating an increase to PATH above the current $20 million?

3--If PPGs do come alive again this session or we revisit them next year, we can work with your office to help ensure that homeless people are served by the block grants.

thanks much

We would not advocate it — in the sense of sending up a budget amendment — because in order to do that, we'd have to find $20 million to cut somewhere else in the Labor, H bill, and many of the POTUS' priorities are there. What we could do, however, is not oppose any increase

EXECUTIVE OFFICE OF THE PRESIDE
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26-Jun-1996 11:14am

TO: Nancy-Ann E. Min

FROM: Molly Brostrom
Domestic Policy Council

CC: Jeremy D. Benami
CC: Douglas L. Steiger

SUBJECT: PATH program

Jeremy and I, and Doug Steiger of your office, met yesterday afternoon with the National Coalition for the Homeless who raised several issues with us regarding the PATH program that we would like you to consider. (As you may know, the Interagency Council on the Homeless is a working group of the DPC so we're fairly involved in homelessness issues across agencies.)

PATH was created to help states provide community-based services for people with serious mental illness who are homeless or at imminent risk of homelessness. The program was funded at $29 million in FY 95 and $20 million in FY 96.

For FY 96 and 97, we proposed to fold it and the Mental Health Block Grant (MHBG) into a Performance Partnership Grant (PPG). For FY 96, we proposed level funding; for FY 97, after Congress added back more to PATH and MHBG than we expected them to, we ended up proposing decreased funding.

The National Coalition for the Homeless is very much opposed to the merger in the PPG. They claim that experience demonstrates that homeless people won't be served unless money is specifically targeted, and that there are not sufficient teeth in the PPGs to ensure homeless people are served.

We have three requests/suggestions:

1) Rep. Pelosi introduced an amendment to keep PATH as a separate line-item in FY 97. Since it looks unlikely that the PPGs we have proposed will be authorized this year, we suggest that we not oppose Pelosi's amendment, i.e. allow PATH to remain a categorical program this year.

2) We have also been asked to push for increased funding for PATH. If we find ourselves in a position to do so, we think an increase could be very helpful, given that our proposed FY 97

level is below FY 96 and perhaps more importantly, given the recent SSI change.

As you know, we signed legislation this year which eliminates alcoholism and drug abuse as criteria for eligibility for SSI. There is a good chance that many of the people who are no longer eligible for SSI will be homeless/at risk of homelessness, and may have mental health as well as substance abuse problems. An increase to PATH may be an additional way to address the expected impact of the SSI change (50,000 people are estimated to be no longer eligible for SSI).

3) Finally, we were not involved in the development of the PPGs, and so are not sure what sort of teeth do exist, but we would

like to work with your staff to ensure that the PPGs contain adequate safeguards to ensure that homeless people are served by block grants.

We'd be happy to sit down and talk with you or your staff further if you have questions. Thanks.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

26-Jun-1996 12:49pm

TO: Molly Brostrom

FROM: Nancy-Ann E. Min
Office of Mgmt and Budget, HP

CC: Jeremy D. Benami
CC: Douglas L. Steiger

SUBJECT: RE: PATH program

i agree with all of your suggestions. I had already instructed Doug that while I still think the PPGs are a good idea, it has gone nowhere, and I do not want to fall on my sword over it with such a small issue such as this one. (I am not sure they agree, but that is my position!). The only potential problem I see is that if Rep. Pelosi's amendment is not just to increase funding for PATH, but to cut something else in order to give the money to PATH, we may find ourselves in a bit of a conflict. But hopefully it will come up in such a way that we can finesse it.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

26-Jun-1996 01:01pm

TO: Nancy-Ann E. Min

FROM: Douglas L. Steiger
Office of Mgmt and Budget, HD

CC: Molly Brostrom
CC: Jeremy D. Benami

SUBJECT: RE: PATH program

The Pelosi Amendment just took the $20 million out of the Mental Health PPG and basically continues the final FY96 situation. Here's the numbers ($ in millions), for your information:

	FY96	FY97 Budget	FY97 Chairman	FY97 Cmte (post-Pelosi)
MH PPG	275	275	295	275
PATH	20	0	0	20

Livingstone

6/25 Mary Ann Gleason

Educ for Homeless kids ⇒ support 29M in 97 approps
Big Impact of extended sch day

97 Approps
H ⇒ 23 M Rep. Slaughter - moderate
S ⇒ no indication
20% cut will be felt at beg of next sch year
(forward funded)

Ques - about teeth in pert p's steps

PATH
$232 / client - in existence since 1990

Can we support PATH as sep. line-item
Support for T? to 27
- Domenici
- Specter

Ques of revisiting?

SAMSHA unauthorized
- more $ added back to LaSalle

PATH → bl grant

- Doug Steiger 5-3894

- Rosemary Hickey Yates
Edwin Lao 5-4689

- Emerg Community Services
Cynthia Smith for PH 5-7761

Current Status of PATH and Health Care for the Homeless

April 11, 1996

Health Care for the Homeless

Most grant awards for FY96 have been made at a 95% funding level. Since both houses of Congress, and last year's budget were all set at $65.4 million it is assumed that their budget is the same under the CR as a cluster.

For PY 96+97, the Admin. proposed consolidating into Consolidated Health Centers cluster.

In FY 95 ~~Path~~ HCH received $65 million. Though there has been no legislation authorizing the Consolidated Health Centers Cluster, funds for FY 96 are being appropriated as if the consolidation had occurred. Both the House and the Senate are currently working on authorizing this cluster.

Pres' FY97 budget: Consol HCHs Cluster @ $757M → flat funding for CMHCs + HCH

Logic: Most Health Care for the Homeless programs are run out of Community Health Centers. As a result, combining both programs into the same grant package (called the Consolidated Health Center Cluster), will greatly reduce the application process for grantees.

PATH - Projects for Assistance in Transition from Homelessness (PATH)

FY 96 and 97 Presidential budget has path under the Performance Partnership Grants (PPG) which combines path and Mental Health Block Grants (MHBG). Path funds are being distributed now, however, the Senate has suggested that path be funded separately from the MHBG with $20 in FY96 (with an additional $250 for the MHBG's). The President's FY 96 request is $304 million which is the same amount as the 95 funding for Path and MHBG's combined. The Presidential Budget FY 97 request for the PPG's, however, is only $275 million -- this is the amount spent on MHBG's in 1995. The FY 97 request essentially adds path to the block grant without providing additional funds (though the states will be free to use these grants however they see fit, including on PATH).

Logic: HHS proposed consolidating PATH into PPG's. PPG's are meant to let states focus on their most critical needs instead of requiring states to follow stringent Federal spending requirements. If PPG's are passed by the states they will increase accountability, provide flexibility, and are meant to better target vulnerable populations. If PPG's become a reality, states would, theoretically, be free to spend all of their money on PATH programs.

Program	FY95	FY96 Pres.	FY96 Senate	FY97 Pres.
PATH	29	-	20	-
MHBG	275	-	250	-
PPG	--	304		275
Totals	304	304	270	275

S.A. block grant
1.234B 96
1.271 → 97
+50M
H: 1.234B

-congress put back in as line-item in 96

FY96 enacted
20
275
295
} they added more $ back than we expected (# originally zeroed at PATH)

Withdrawal/Redaction Marker
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. note	handwritten re meeting attendees (partial) (1 page)	nd	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Molly Brostrom
OA/Box Number: 8395

FOLDER TITLE:
PATH [Projects for Assistance in Transition from Homelessness] Access

2012-0326-S
kc731

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[001]

THE WHITE HOUSE

WASHINGTON

Mary Ann Gleason
David Berriss
Barbara Duffield

P6/(b)(6) — 2/15

- HC for H'less prog in Albuquerque → model prog for SA
- PATH: House kept separate – we won't fight
  why we proposed: ↓ costs; try to get mainstream program to do what they're supposed to.
- Educ for H'less
- Mck funding { 25% kept at nat'l comp'. ⇒ need to ~~match~~ local
  model programs going
  + smaller counties
- $50 M SSI – DA&A – for treatment into bl grant – "reneged"
  – not just targeted (i) HIV – focused on some $ DA&A

- In theory, M-Ann is right

- But in practice → no new dollars, no new programs

HUD: competitive

HHS: mostly bl grant (except HCH)

- not just territoriality, a lot is statute → need to go to Congress - but unwise @ moment

Our bl grant proposal: unless
merge 3 programs → to communities - allow them to allocate
SRO
SHP
Shelter Plus Care
min. 50% to non-profits

- more impt to help us w/ Congress' support for pieces such as reg's & tenant partic. on boards

Multiple Diagnosis
- t.a
- task force to look @ other things to do
  - issue is resources → retargeting

Current Status of
PATH and Health Care for the Homeless
April 11, 1996

Health Care for the Homeless
In FY 95 Path received $65 million through its own line item. The administration has proposed putting this program into the Consolidated Health Centers Cluster in FY 96 and Fy 97. Though there has been no legislation authorizing the Consolidated Health Centers Cluster, funds for FY 96 are being appropriated at FY 95 levels (almost as if the consolidation had occurred). Both the House and the Senate are currently working on authorizing this cluster.

Recent activity in the House(?) suggests they may keep HCH funding at proportional FY 95 funding for the next two or three years.

Dr. Marilyn Gaston, director of HRSA's Bureau of Primary Health Care. would like input into the reorganization of HCH and the BPHC, which are currently seperate, but which may be merged if the block grant takes place.

Logic: This will reduce the burdens for grantees -- about 50% of which are Community Health Centers. This will also allow more flexibility to focus on the needies populations.

National Coalition for the Homeless

The Health Care for the Homeless Program

Congress should pass S.1044, or its equivalent, in order to reauthorize the national Health Care for the Homeless Program. The reauthorizing legislation must include 5 years of distinct funding for the HCH program.

Congress and the Administration should continue to support targeted, comprehensive health services for homeless people through adequate funding for the Health Care for the Homeless Program.

The Program

The Federally funded Health Care for the Homeless program was created as Section 340 of the Public Health Services Act by the Stewart B. McKinney Act of 1987. Building on the experiences of 19 projects funded by the Robert Wood Johnson Foundation and Pew Charitable Trusts, this program has demonstrated that health care programs targeted to homeless people can effectively reach this very vulnerable and seriously ill population.

It is clear that targeted funding for health care services to people who become homeless is necessary. Poor health contributes to homelessness, is caused by homelessness and treatment is dramatically complicated by homelessness. This means that homeless people require a continuum of comprehensive health care services. In recent years, indigent care systems have been overwhelmed by demand associated with rising poverty rates and the growth in the numbers of uninsured Americans. The indigent care infrastructure (including rural and inner-city hospitals, public clinics and solo practitioners) is also operating under threat from the consolidation of health care and the growth of for-profit managed care companies that are not anxious to serve vulnerable populations.

Health Care for the Homeless projects provide accessible and comprehensive health services to people who become homeless in an effort to improve their health. These projects provide an integrated model of care which is effective in improving the quality of lives of homeless persons. The HCH model includes primary and preventive health care, mental health and addictions services, case management, transportation and translation services and, of course, assistance in securing housing and an income.

In fiscal year 1995, the HCH program provided grants to 122 community-based organizations and, through them, to over 300 subcontractors. These include free-standing clinics, community and migrant health centers, local health departments and community coalitions. The HCH program served over 450,000 homeless men, women and children in 1995.

Reauthorization

S.1044, sponsored by Senator Kassebaum (R-KS), would consolidate health center programs (including Community Health Centers, Migrant Health Centers and Health Centers in Public Housing, along with HCH) under a single section of the Public Health Services Act. While the reauthorization would run for 5 years, S.1044 maintains proportionate funding for each of the previously distinct

1612 K Street, NW #1004 • Washington, DC 20006 • 202/775-1322 • Fax: 202/775-1316
Email: nch@ari.net • Homepage: http://nch.ari.net • Handsnet: HN0055

sections for only 3 years. During the last two years of the authorization, the HHS Secretary is supposed to insure that funding is distributed to meet the needs of vulnerable populations.

- S.1044 has been reported out of committee and awaits action on the floor of the Senate. There is currently no viable alternative legislation in the House of Representatives. **Ask members of the House to support legislation that would reauthorize the Health Care for the Homeless Program with targeted funding for at least 5 years. Members of the House Commerce Committee, chaired by Representative Bliley (R-VA) and of its Subcommittee on Health and Environment, chaired by Representative Bilirakis (R-FL), would be responsible for such legislation and are thus especially important.**

- **Urge Senators to ask Senator Dole to schedule S.1044 for a vote and, of course, to support its passage. Senators Kassebaum (R-KS), Kennedy (D-MA), Jeffords (R-VT), Pell (D-RI) and Simon (D-IL) are the key players on this legislation in the Senate.**

Appropriations

The Senate and House have so far been unable to come to an agreement on funding for the entire government, including programs that serve poor and homeless Americans, for the remainder of FY 1996. H.R. 3019, the Balanced Budget Downpayment Act, would provide funding for the government for the remainder of the year, until September 30. This bill includes level funding ($65.4 million) for the Health Care for the Homeless program.

- The lack of a full year's appropriation creates significant uncertainty regarding the availability of health care for homeless persons throughout 1996. **Members of Congress should be urged to move quickly to pass H.R. 3019, with HCH funded at 100% of the FY95 level of $65.4 million.**

Maintaining targeted funding for the HCH program is essential, however, making sure that funding is adequate is also important. In his proposed FY97 budget, President Clinton funds HCH as part of a "consolidated health centers cluster" at $757 million. This would flat fund Community and Migrant Health Centers, Health Centers in Public Housing and Health Care for the Homeless at a time when demand for health care among underserved and vulnerable populations is increasing dramatically. Furthermore, in the past 5 years, the health center programs have lost more than $40 million in dollar value, as their funding has slipped from the equivalent of $800 million to $757 in 1997 dollars.

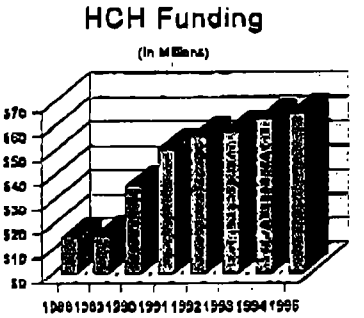
- **To make up for this loss, we recommend an additional $75 million ($832 million total) be provided for the consolidated health centers for fiscal year 1997.** This would provide a 10% rise in funding overall and close to $72 million for the Health Care for the Homeless Program. In turn, this money will generate increases in state and local matching dollars, increasing the quality and amount of services available to the most vulnerable Americans.

Health Care for the Homeless
Fact Sheet

The Federal Health Care for the Homeless Program (HCH) was created in 1987 with the passage of the Stewart B. McKinney Homeless Assistance Act. The HCH program awards discretionary grants for health care delivery to people who are homeless. Eligible applicants for the grant awards are local private nonprofit organizations and public entities which target the health needs of homeless individuals and families.

The HCH program recognizes the diverse health related needs of homeless persons and requires a coordinated, comprehensive response. The HCH programs:

- Provide for primary health care and substance abuse services at locations accessible to homeless persons;
- Provide for emergency care with referrals to hospitals for inpatient care services and/or to mental health services as needed;
- Provide for outreach services to access difficult to reach homeless persons, and for aid in establishing eligibility for entitlement programs;
- Develop community coalitions composed of health care providers and social service agencies to complement existing health and social services; and
- Obtain commitments from communities for social service support and financial contributions to programs serving homeless persons.



To ensure Federal grant dollars are maximized, grantees are required to obtain matching funds (33 1/3 percent nonfederal match for continuation grantees and 25 percent match for new grantees) from nonfederal sources. Also, HCH programs are encouraged to develop or participate in coalitions composed of community health care providers and social services agencies to ensure adequate and appropriate services for persons who are homeless.

HCH appropriations by fiscal year are as follows:

Year	1987	1988	1989	1990	1991	1992	1993	1994	1995
Appropriation*	$46.0	$14.3	$14.8	$35.7	$51.0	$56.0	$58.0	$63.0	$65.4

*all numbers in millions

Health Care for the Homeless Successes:

- In 1994 these funds provided assistance to 123 grantees in 48 states, DC, and Puerto Rico.
- Nearly one in eight (12%) of HCH grants were awarded to rural communities; 25% of persons served resided in rural areas.
- Programs provided 2,020,972 encounters to 457,447 users in 1994.
- Subcontractor relationships were established with 329 organizations to supplement services provided by grantee organizations.
- Since 1988, the number homeless persons receiving care from HCH programs increased 16 percent per year, on average.
- Fifty seven percent of users had no medical care resources. Medical care resources available to some users included Medicaid (19%), Medicare (2%), private insurance (2%), self-pay (2%), and VA medical (2%).

PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH) FACT SHEET 1994

WHO ARE THE PROVIDERS OF PATH-SUPPORTED SERVICES?

- 395 local organizations provide services to persons who are homeless and have serious mental illnesses
- 55% of these providers are community mental health centers; other types of providers include social service agencies, health care providers, and housing providers
- Over 2,000 persons are engaged in the provision of PATH-supported services to clients who are homeless and have serious mental illnesses

WHAT SERVICES ARE OFFERED?

- 84% of all providers perform outreach to persons who are homeless
- 83% of providers offer case management services
- 74% of providers use PATH funds to assist clients in accessing primary health care services, job training, education services, and housing
- Additional services provided include community mental health services, supportive and supervisory services in residential settings, and substance abuse services

WHO ARE THE CLIENTS THESE PROVIDERS SERVE?

- In Fiscal Year 1994, over 127,000 persons received outreach or other PATH-supported services
- According to demographic information provided by the States, for those clients for whom demographic information was available:

  - 3% of clients were children under 18
    93% were adults ages 18-64
    3% were adults ages 65 or older

  - 65% of clients were male
    35% of clients were female

  - 53% of clients were Caucasian
    32% were African-American
    15% were of other races

    21% of clients were of Hispanic origin

- Persons receiving PATH-funded services have some of the most disabling mental disorders. Among clients for whom a diagnosis was made:

  - 73% of clients had schizophrenia and other psychotic disorders
    14% had affective disorders such as depression
    13% had personality disorders or other mental disorders

- Nearly 50% of persons served had a co-occurring substance use disorder in addition to a serious mental illness:

- At the time of first contact with providers supported by the PATH program:

  - 43% of clients served lived on the street or in emergency shelters
  - 24% lived in temporary housing settings
  - 33% of clients lived in private or other residences, psychiatric hospitals, or other settings

- Many of the clients served had been homeless for considerable periods of time. During their most recent episode of homelessness:

  - 32% had been homeless for less than 30 days
  - 33% had been homeless for 30-90 days
  - 22% had been homeless for 90 days - 1 year
  - 13% had been homeless for more than one year

WHAT IS THE ROLE OF THE STATE MENTAL HEALTH AUTHORITIES IN ADMINISTERING THE PATH PROGRAM?

- In Fiscal Year 1994, the PATH program distributed nearly $29 million in Federal funds through formula grants to each State, the District of Columbia, Puerto Rico, and the U. S. Territories
- States are required to match a each three dollars in Federal funds with at least one dollar of State or local funds. In FY 1994, States well-exceeded the minimum level of matching funds, providing over $20 million in funds to match the $29 million Federal allocation.
- The States select providers based on their assessment of mental health needs among persons who are homeless and oversee providers' use of PATH funds
- States provide training and technical assistance to local service providers.1

National Coalition for the Homeless

Projects for Assistance in Transition from Homelessness (PATH)

Congress should work to meet the needs of people with severe mental illness who become homeless through adequate funding for the Projects for Assistance in Transition from Homelessness (PATH) program.

Congress should ensure the continued existence of the program by passing S. 1180, the Substance Abuse and Mental Health Services Administration (SAMHSA) Reauthorization, Flexibility Enhancement and Consolidation Act of 1995.

The Program

The Projects for Assistance in Transition from Homelessness (PATH) grant program was authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. It is administered by the Center for Mental Health Services under SAMHSA. The PATH program was created to help states and territories provide community-based services for people with serious mental illness who are homeless or at imminent risk of becoming homeless.

PATH programs have proven very successful in reaching out to people who have been alienated from mainstream systems of care. PATH services eliminate the "revolving door" of episodic inpatient and outpatient hospital care. Multi-disciplinary teams address client needs within a continuum of services, providing needed stabilization so that mental illnesses and co-occurring substance abuse and medical issues can be addressed. Assistance is provided to enhance access to housing, rehabilitation and training and other needed supports. Without targeted funding for this purpose current providers will not be able to accommodate the particular needs of mentally ill homeless people, who will be left to wander the streets untreated and risk being hospitalized at the most expensive point of care.

Federal, state and local PATH funds are often the only resources available to communities to support the types of services that are necessary for homeless people with severe mental illnesses: **outreach** to those outside the mental health system, **engagement** in treatment and services and **transition** to mainstream mental health treatment, housing and support services. **PATH works - it meets a need no other program meets and, in so doing, reflects a wise use of scarce resources.**

Appropriations

Until 1996, from $29.4 - 33 million was appropriated annually for PATH. For every $3 dollars of federal funds provided, a $1 match in non-federal funds is required. Services provided by PATH dollars include outreach, screening and diagnostic treatment, rehabilitation, alcohol and drug treatment, staff training, case management, supportive services in residential settings and assistance in gaining housing. Not more than four percent of a state's allocation can be used for administrative expenses.

In 1994, 395 agencies reported providing one or more PATH-funded services to 127,231 people, using $29 million in Federal funds and an additional $20 million in State and local matching funds. On average, PATH funds represent more than 25% of the funds used by local provider agencies to

1612 K Street, NW #1004 • Washington, DC 20006 • 202/775-1322 • Fax: 202/775-1316
Email: nch@ari.net • Homepage: http://nch.ari.net • Handsnet: HN0055

serve homeless individuals with severe mental illnesses. Without these funds, vulnerable individuals would not be connected to needed services.

- Congress has so far failed to pass an authorization for PATH for FY 1996. **Because SAMHSA believes that it has no spending authority for PATH grants for FY96, it has not begun the process of soliciting information from states in order to release such funding. We believe that the current continuing resolution gives SAMHSA the necessary spending authority and that it should begin the grant process immediately.**

- House and Senate conferees on H.R. 3019, the Balanced Budget Downpayment Act, have agreed to provide $20 million for PATH in FY96. While this is a substantial reduction from FY95, it provides for PATH's continued existence. **Members should be encouraged to support H.R. 3019 and should be asked to speed its passage. PATH programs will begin to shut down in the next few months if this situation is not resolved now.**

- In a recent letter from HHS Assistant Secretary John J. Callahan, the Administration has professed its strong support for programs that serve homeless persons with mental illness. However, the President's proposed FY 1997 budget will effectively end the PATH program by consolidating it within the former Mental Health Block Grants (now called Performance Partnership Grants) with no additional funding. **We urge you to contact Assistant Secretary Callahan and let him know that the administration should show its support for services to homeless people with mental illnesses by funding those services. Secretary Callahan can be reached at 202/690-6396.**

Reauthorization

The Substance Abuse and Mental Health Services Administration (SAMHSA), which administers the PATH program, is subject to reauthorization this year. S. 1180, the SAMHSA Reauthorization, Flexibility Enhancement and Consolidation Act of 1995, sponsored by Senator Kassebaum, has been voted out of committee and currently awaits action by the Senate. In the legislation's current form, PATH has been preserved as a distinct funding stream. There does not seem to be a great deal of enthusiasm for the SAMHSA reauthorization at this time and the bill may not come up for a vote in either house this year. This means that SAMHSA's continued existence would depend entirely on the appropriations process and on the willingness of Congress to continue to fund unauthorized programs.

- The Administration and the House Appropriations Committee have tried to consolidate PATH within the Mental Health Block Grants, which primarily fund Community Health Centers. Because CMHCs have not historically targeted funding to activities for mentally-ill homeless people, **it is likely that any effort to incorporate PATH within Mental Health Block Grants will substantially reduce resources available to PATH programs.**

- Homeless people with mental illnesses are among the most vulnerable of all Americans. A recent survey of 29 cities conducted by the U.S. Conference of Mayors found that 23% of homeless persons had a serious mental illness. Mental illness and the lack of needed services was identified by 16 of the 29 cities as a main cause of homelessness. **Failure to provide targeted PATH funds to the states places thousands of people at risk of losing access to needed services. Reauthorization within S. 1180 will make future targeted funding much more likely.**

facsimile
TRANSMITTAL

to: Molly Brostrom
fax #: 456-7028
re: Health Care for the Homeless and PATH
date: April 11, 1996
pages: 2, including this cover sheet.

Please see the attached overview of the two programs.

--Mike

PATH funded at 20M - not folded in
Next year → unlikely
Kassebaum our ally after PBOs - not there - unlikely.

PATH + HC for Homeless Conferences

From the desk of...

Michael Shoag
ASPE, HHS
HHH Bldg. Room 440d
200 Independence S.W.
Washington, D.C. 20201

(202) 260-0285
Fax: (202) 690-8252

SAMHSA
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

CMHS MISSION

Bernard S. Arons, M.D., Director
Thomas H. Bornemann, Ed.D., Deputy Director

The worn face of a mother's untreated mental illness, the empty gaze of a child who is seriously disturbed and unserved, the emotional scars of a victim of domestic violence and sexual abuse, the nagging sight of people with mental disorders who are homeless....

These are among the images that led Congress to create the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration, one of the Public Health Service agencies in the Department of Health and Human Services.

The Center's mission is to bring new hope to those who live with a serious mental or emotional disorder by leading Federal/State partnerships to demonstrate, evaluate and disseminate service delivery models to treat mental illness, promote mental health and prevent the development or worsening of mental illness when possible.

Public Law 102-321 mandates the Center's leadership role in mental health services delivery and policy development. Toward that end, Center activities involve facilitating the development and application of scientifically established findings and practice-based knowledge to prevent and treat mental disorders, and improving access, reducing barriers and promoting high quality, effective programs and services for people with -- or at risk for -- these disorders.

Center programs and staff help States improve the quality and range of treatment and support services to people with mental illnesses, their families and their communities. A wide range of programs demonstrate effective responses to the increasing number of mental, emotional and behavioral problems among America's youngsters, and programs of outreach and case management for the thousands of Americans who are homeless and severely mentally ill. They support efforts to help States and communities improve rehabilitation services and they encourage the creation and effectiveness of consumer self-help alternatives. They sponsor policy studies, evaluations and assessments that will help policymakers at every level of government organize and finance systems of care, of critical importance as the Nation moves toward managed care delivery systems.

In addition to working with State and local governments to promote, evaluate and replicate integrated services and improved access to comprehensive systems of care, the Center collaborates with other Federal agencies and departments whose programs affect the lives of people with mental illnesses to enhance mental health services delivery and policy development.

Center for Mental Health Services, 5600 Fishers Lane, Rm 15-103, Rockville, MD 20857 • 301-443-2792 • FAX 301-443-9183

SAMHSA

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services

HOMELESS SERVICES PROGRAM

THE PEOPLE WE SERVE

Gladys didn't like shelters (and she had tried many over the years), but one bitter cold night a few years ago, she tried out a new shelter a young street worker had recommended. After a few weeks, Gladys started a fight with the woman in the next cot, who, she believed, was sending her messages through the television. Most shelters simply sent Gladys back on the streets when she got into fights, but this one was different. Outreach workers from a mental health center were able to assess her and take her to the center for treatment.

Medications silenced the voices, and she started to feel better. Her case manager arranged for her to move temporarily to the center's supported residence for homeless people with mental illnesses. By now, Gladys, working with her case manager, was able to start attending to the rest of her life--what she called "the gettings": getting someplace permanent to live, getting good medical care (including surgery to make her hand more usable), getting off alcohol and other drugs, and getting some education and training so she could get a paid job instead of living on welfare. She also talked about the "givings": using her considerable street wisdom and native intelligence to help other people.

- It is difficult to know exactly how many Americans are both homeless and have serious mental illnesses--this includes people on the streets, in jails and in emergency shelters.

- On any given night throughout the country, even by conservative estimates, up to 600,000 people are homeless. An estimated one third have serious mental illness. Over half also have an alcohol and/or drug problem.

- Minorities, especially African Americans, are over-represented among homeless persons with mental illnesses.

- The complex needs they present are extraordinary. Homeless persons with mental illnesses often are reluctant to accept shelter and mental health treatment because of prior negative experiences. In addition to

mental health treatment, they need primary health care, substance abuse treatment, legal assistance, help accessing entitlements, and other supports while they learn to abandon skills that helped them survive on the streets. Few providers can address this range of needs.

- CMHS was the lead Federal agency on the **Federal Task Force on Homelessness and Severe Mental Illnesses,** and provided coordination and oversight for the implementation of 58 action steps to promote systems integration, outreach, access, housing options and alternative services.

- The Center provided leadership in implementing **Priority: Home! The Federal Plan to Break the Cycle of Homelessness,** through co-chairing the Mental Health and Substance Abuse Work Group that developed an action plan to implement the mental health and substance abuse treatment, housing, and supportive service recommendations contained in the Federal Plan.

- The Homeless Programs Branch works extensively with State mental health authorities to ensure adequate, appropriate services through the Projects for Assistance in Transition from Homelessness (PATH), a formula grant program.

- The Center supports a demonstration program, Access to Community Care and Effective Services and Supports (ACCESS), to identify effective strategies for creating integrated systems for homeless persons with severe mental illnesses.

- CMHS supports a collaborative demonstration program with the Center for Substance Abuse Treatment to develop and evaluate models of effective treatment for homeless individuals with co-occurring serious mental illnesses and substance use disorders.

MANDATE

- The Homeless Demonstration Programs for homeless mentally ill and dually diagnosed individuals are authorized by Sections 506 and 520 A (e) of the Public Health Service Act. The PATH program is authorized by Section 535 (a) of the Public Health Service Act, and the Stewart B. McKinney Homeless Assistance Amendments Act of 1990 (Public Law 101-645, Title V, Subtitle B).

FUNDING

FY '95 Appropriation	
Homeless Demonstrations:	$ 21,227,000
PATH:	$ 29,462,000

STATUS

- Access to Community Care and Effective Services and Supports (ACCESS) is a new five-year national demonstration program for cooperative agreements involving nine states and two communities within each state to care for homeless persons with serious mental illnesses, including those who also have alcohol and/or other substance use disorders. ACCESS will demonstrate and evaluate different approaches to integrating service systems that will improve the availability, accessibility, efficiency, accountability and effectiveness of services. The Departments of Health and Human Services and Housing and Urban Development worked with the Departments of Labor, Education, Agriculture and Veterans Affairs to establish the ACCESS program.

- The PATH formula grant program funds States, the District of Columbia, Puerto Rico and the U.S. Territories to support services for persons with serious mental illnesses, as well as those who also have substance use disorders, who are or may become homeless. Services include: outreach, screening and diagnosis, habilitation and rehabilitation services, community mental health services, alcohol or drug treatment (for mentally ill individuals with co-occurring substance use disorders), staff training, case management, supportive and supervisory services in residential settings, and referral for primary health services, job training and education. In addition, to improve coordination of services and housing for homeless persons with mental illnesses, a limited set of housing services may be funded.

- States distribute PATH funds to local provider agencies, including county and municipal government entities and non-profit organizations, for the delivery of these services.

- The Center is collaborating with the Center for Substance Abuse Treatment (CSAT) to develop and evaluate treatment models for individuals with co-occurring mental illnesses and substance use disorders. In FY 1994, approximately $2.2 million was awarded via cooperative agreements to six organizations for this two-year demonstration project.

Total CMHS contribution in FY 94:	$1,400,000
Total CSAT:	$ 802,000
Total FY '94 CMHS and CSAT:	$2,202,000