THE WHITE HOUSE
WASHINGTON

Jim —

Jack Smith

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

15 August 1984

LETTER OF TRANSMITTAL

Dear Mr. President:

It is my pleasure to forward to you my report on ways to help the homeless. When we met on 4 April 1984, you requested that my Department prepare such a report to provide you with background, analysis, and options.

The HHS Working Group on the Homeless has drafted the attached paper for your review. It describes the problem, and summarizes what is now being done by the private sector, states, localities, and the Federal Governement. A strategy for a public/private partnership, focusing on those most in need -- in both the short and long term -- is outlined, and specific options presented.

Considerable progress can be made by improving the service system already in place, allowing for a more effective utilization of current programs. The Federal Government can do more to make sure the homeless receive the benefits to which they are entitled and to provide technical and other assistance to local groups which provide direct services. In addition, a better partnership needs to be developed between local communities and the states in order to improve linkages and fill gaps among existing services.

Sincerely,

Margaret M. Heckler
Secretary

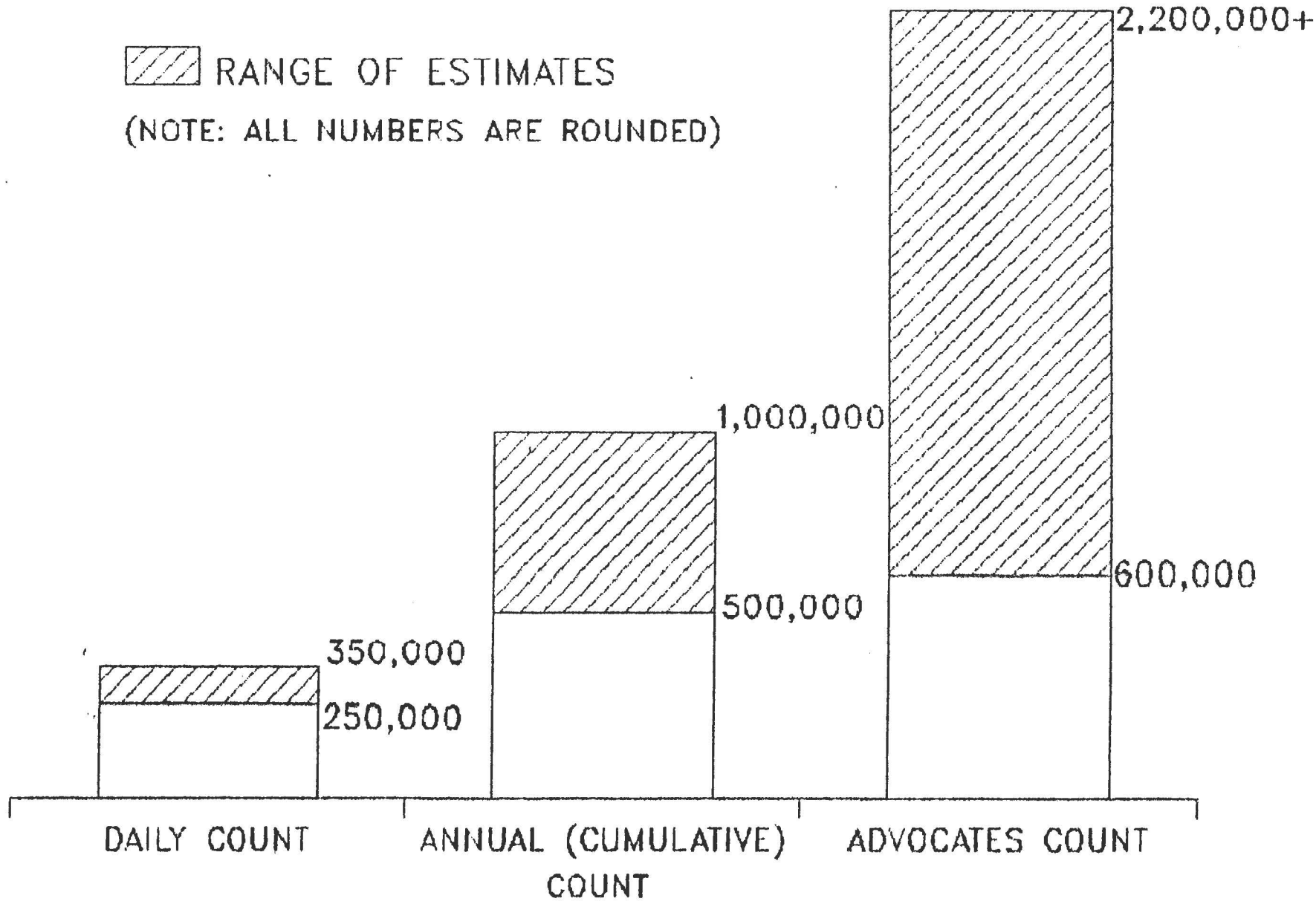
# THE HOMELESS

## Background, Analysis, and Options

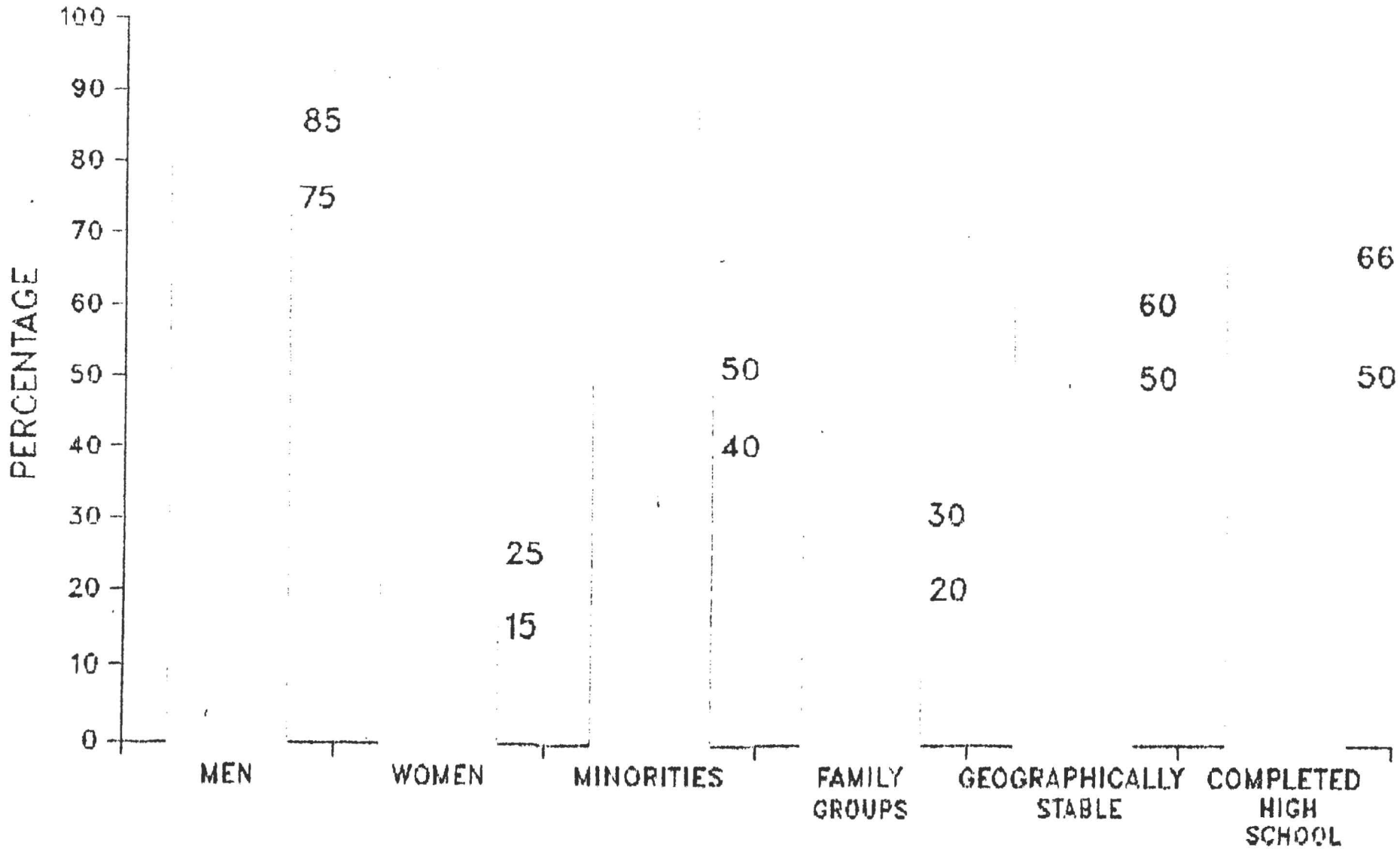
CONTENTS

IV. Specific Options, Continued

# NUMBER OF HOMELESS

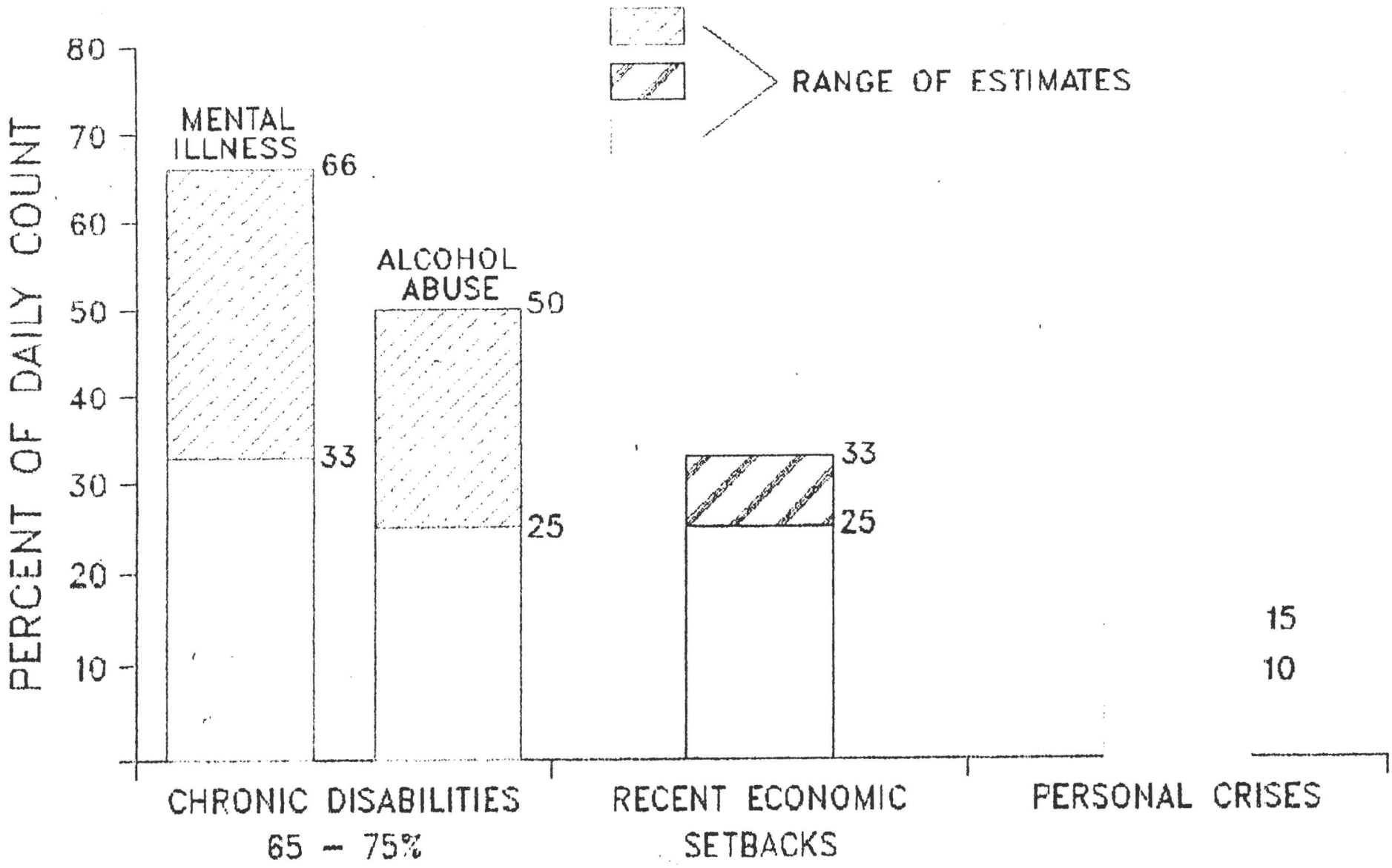


# CHARACTERISTICS




AVERAGE AGE 35

# REASONS FOR HOMELESSNESS




PERCENTAGES DO NOT ADD TO 100% BECAUSE OF OVERLAP

# HOMELESS BRIEFING

## Background, Analysis, and Options

## I. THE PROBLEM

### A. DEFINING "HOMELESSNESS"

Homeless people are those who lack shelter and the financial resources necessary to acquire it, and revert to seeking food and shelter from public or private facilities. This definition is intended to include anyone whose regular nighttime residence is:

- o in a public or private emergency shelter;
- o in the streets, parks, subways, bus terminals, railroad stations, airports, abandoned buildings without utilities, and other outdoor locations; or
- o in temporary voucher hotels, motels, or apartments, or in jails or hospitals with the underlying purpose of seeking shelter.

This definition is somewhat broader than that which might be used to design an appropriate strategic initiative to help the most numerous, destitute and helpless of these people, the mentally disabled and alcohol abusers. The rationale for focusing an initiative on these latter populations is developed throughout the remainder of this paper.

### B. NUMBER OF HOMELESS PERSONS

#### Daily Versus Annual (Cumulative) Counts

The extent of homelessness can be measured by the total number of persons homeless on a given night or by the cumulative number homeless during a year. The first, the daily measure, is useful in analyzing how many emergency shelter beds, meals, and facilities are needed; the latter, the annual (or cumulative) measure, is useful for analyzing how many people need help in a given year. Both types of measure provide needed information, but the two concepts are often not distinguished, creating confusion about how many people are homeless.

## Estimates of the Homeless by Advocates and Service Providers

Prior to 1984, the most commonly published number of homeless persons was 2.2 million. That number was cited in numerous news articles and was used by the U.S. Conference of Mayors and the New York based National Coalition for the Homeless. It was apparently based on the conclusion reached by the Washington, D.C.-based Community for Creative Non-Violence, and reported in 1982, that in 1980 approximately one percent of the population, or 2.2 million people, lacked shelter; this is presumably an annual estimate.

## The HUD Report

On May 1, 1984, Secretary Pierce released a systematic national study profiling the homeless population and emergency shelters.

According to that HUD report, the estimated daily number of homeless persons is between 192,000 and 586,000, most probably between 250,000 and 350,000.

The HUD report indicates that almost half of those homeless on any given day are only episodically or temporarily without shelter. On an annual basis--because of the large turnover--the episodically or temporarily homeless comprise a majority of the cumulative annual count. Taking this into consideration, one can derive a cumulative, annual count ranging between two and three times the daily total.

The HUD report was based on:

- over 500 telephone interviews in a national sample of 60 metropolitan areas;
- a national survey of 184 shelter operators;
- reviews of local studies in over 30 metropolitan areas;
- site visits to ten cities;
- discussions with national organizations; and
- telephone interviews with State government officials in all 50 States.

Furthermore, the report was quite clear in stating that it used a daily rather than an annual estimate of homelessness.

Nevertheless, it was immediately criticized by advocates for the homeless in many newspaper editorials, and in Congressional hearings, as a purely political document intended to deny the reality of an obviously widespread problem and to diminish criticisms of the Administration for not responding to it. Some commentaries, however, dismissed any such discussion as pointless, since even HUD's lower numbers are indicative of a serious problem.

What Number Should be Used?

All current national numbers are based on estimates, not on actual counts. A good strategy would be to assume a broad range and to plan accordingly. What is even more important is to know the causes of this problem and to develop strategies for responding to it, which are more than a quick-fix.

## C. INCREASED PUBLIC AWARENESS

The homeless have been a social phenomenon since the beginning of civilization and have certainly always been a part of America's social history. However, the increasing number of available shelter beds and other services in the past four to five years implies an increase in the number of homeless, an increase in public/community awareness, or both, which has resulted in increased availability of food and shelters.

The issue received increased public attention in the late 1970's and early 1980's. Congressional interest, media coverage, and advocacy concern have certainly increased over the last several years. Since there are no routine surveys of the homeless that provide reliable annual estimates, it is hard to be precise about actual trends in the size of the population, although it appears to be increasing.

## D. CHARACTERISTICS OF HOMELESS PERSONS

The most outstanding characteristic of the homeless is their heterogeneity. Although there are differences among geographic areas, several patterns emerge:

- the homeless are in their mid-thirties, much younger than in the past when they averaged in their mid-fifties;
- about 15 to 25 percent are women, a percentage that seems to be increasing;
- about 40 to 50 percent are minorities, although racial and ethnic composition tend to reflect that of local areas;
- 20 to 30 percent are in family groups;
- about 50 to 60 percent remain in a single city for one or more years, although transiency is more significant in warmer climates; and
- One-half to two-thirds have completed high school, and about 25 to 30 percent have attended college.

## E. REASONS FOR HOMELESSNESS

The factors that contribute to homelessness are both structural and individual. Structural factors include economic changes and problems, urban reconstruction projects that lead to geographical dislocations, and discontinuities in service provision. Individual factors include mental and physical disabilities, and personal crises. The structural and individual factors are highly interactive.

### Chronic Disabilities

#### Mental Illness

From 33 to 66 percent of the homeless in shelters are characterized principally by mental illness, on an acute or chronic basis, and 25 to 35 percent are former patients of mental hospitals. Since there is a higher percentage of mentally ill persons on the streets than in shelters, these percentages probably represent minimum figures for strategic planning.

That such a large proportion is chronically or acutely mentally ill is due to a number of factors:

- o Deinstitutionalization: Originally, this term meant the release of patients from the large, public, State mental hospitals and their return to the community where they would be cared for in more personalized settings. This was made possible and reinforced by:

-- the introduction of new types of medications which provided symptomatic management of seriously mentally ill patients;

-- the emergence of community mental health centers to supplement care in private homes;

-- the availability of Federal entitlements, such as Medicaid, Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI) to help finance such living arrangements and care;

-- a philosophy of care in which the large State hospitals were perceived as dehumanizing; and

-- a sensitivity to civil rights resulting in procedural safeguards against involuntary hospital admissions.

Concerning the latter point, a series of court cases (Wyatt v. Stickney; O'Conner v. Donaldson; and Dixon v. Weinberger) extended to mental health patients the "right to the least restrictive alternative" for care. Others (Rozechi v. Ganghan and Kaimowitz v. Michigan) extended to them the "right to refuse treatment."

Long-term residence in a State mental hospital or other inpatient mental institution is now the exception, with the emphasis on providing mental health outpatient and partial care treatment in the community, and reducing the length of hospital stay as much as possible. State hospitals for the mentally ill have generally adopted strict admission policies, only admitting those with the most obvious symptoms and dangerous behavior. Typically, State laws and the courts have supported this policy.

As a result, while there were 559,000 persons in State mental hospitals in 1955, there were only 125,000 in 1981. Because of the turnover in the institutionalized population, the number deinstitutionalized during this period is higher than a simple subtraction of the two numbers would indicate.

This aspect of deinstitutionalization has clearly resulted in a far greater number of chronically mentally ill persons residing in the community today than in the past. Many of these chronically mentally ill persons do not receive a systematic program of community-based mental health care and supportive services.

Moreover, many of the current mentally ill homeless did not seek or receive treatment from either State hospitals for the mentally ill or community-based mental health care systems. Others were diverted from inpatient care. It is particularly in these latter cases that "deinstitutionalization" may have been a contributing factor in the growth of the mentally ill homeless population.

This latter group frequently exhibits an inability to cope with the complexities of daily life or to understand how to apply for entitlements or take advantage of available services.

Many of these are younger adults who are part of the baby boom generation, which has increased dramatically the numbers of individuals between the ages of 18 and 35, the age group most at risk for the onset of some serious mental disorders such as schizophrenia.

o Availability and Organization of Community Care Programs:

Although there are many cases in which the transfer of patients from State mental hospitals into community care has been successful, most communities were, and still are, unable to care for and manage the complex needs characteristic of the chronically mentally ill in the community. Among the reasons are the unavailability of services and the lack of effective integration among services that are available.

Today, deinstitutionalized mentally ill persons can be found in a range of community settings where the availability and accessibility of a continuum of treatment and rehabilitative services varies greatly. Thus, many chronically mentally ill persons do not gain the benefits from services which could help them maintain a stable existence and obtain adequate employment, shelter, and the like. Some have no contact with mental health care at all; others may have been referred for short-term assistance upon release from a hospital, but are no longer eligible or may have dropped out of programs. Still others may come into contact with mental health service systems only when their illness becomes so severe that they are hospitalized.

Gaps in the availability of appropriate residential placements have forced many chronically mentally ill persons to rely on shelters in lieu of more appropriate housing. In fact, some researchers suggest that shelters are not serving as transient way-stations for the homeless, but instead, have become alternative institutions to house a large number of mentally ill persons. They also point out that such facilities generally do not provide the necessary treatment and other supports needed by the chronically mentally ill and that their personnel sorely lack training as well as access to trained mental health personnel needed to work with chronically mentally ill persons.

## Alcohol Abuse

The alcohol abuser has traditionally been the archetypical homeless individual. Reports indicate that persons with a primary disability due to alcohol abuse are no longer the overwhelming majority they were in the past; however, they still make up a significant share, perhaps 25 to 50 percent or more of the daily total.

Some overlap exists among alcohol abusers and the mentally disabled. In many instances, the symptoms of alcohol abuse may mask underlying psychiatric disorders. The two groups may be 65 to 75 percent or more of the daily estimate of the homeless.

## Loss of Single Room Occupancy Units

"Gentrification"--the rehabilitation of downtown housing for new affluent purchasers--and the demolition of low-cost residential hotels and boarding houses in urban reconstruction projects have both depleted the supply of single-room occupancy units which are often the homes of very low income individuals. Between 1970 and 1980, about one million rooms--nearly one half the Nation's total --were converted to other uses or destroyed. In general, these have not been replaced.

## Economic Conditions

In early 1984, at least 35 to 40 percent of the shelter population were believed to have suffered recent economic setbacks, such as unemployment and eviction. However, most of these people have been "at the margin" for some time. This phenomenon should diminish as a result of continued economic recovery which has already created over 6.5 million new jobs.

## Personal Crises

Very few, perhaps 10 to 15 percent, of the daily homeless population are homeless due to personal crises such as divorce, being released from a jail or hospital with no place to go, being stranded while traveling, domestic violence, and health-related problems. These conditions are usually temporary rather than chronic, and a large turnover is common among this group. Thus, they may comprise a much larger percent of the cumulative annual population.

# II. HELP NOW BEING PROVIDED

### A. PRIVATE SECTOR AND VOLUNTARY PROGRAMS

The vast majority of efforts to assist the homeless are being undertaken by the private sector, including businesses, local, non-profit groups, churches and synogogues, and other voluntary organizations. Activities include:

- o emergency overnight shelters, many of which also serve meals;
- o vouchers to provide overnight lodging in hotels, apartments, and motels;
- o transitional housing, where families or individuals may stay for several weeks or months while working out their problems;
- o emergency feeding stations;
- o food pantries, which provide several days' supply of groceries;
- o food banks, which collect nonmarketable food from retailers, processors, and growers; store it; and redistribute it at very low cost to charities, including emergency feeding stations.

There are about 110,000 emergency shelter beds and 300 food banks. The number of food pantries and emergency feeding stations is not known, but they are numerous.

Such services have increased dramatically in recent years, an indication of the upsurge in need and the response to it. Most of the food banks have opened in the last five to ten years; 40 percent of all shelters are less than four years old.

In addition to local projects, at least one national initiative has been sponsored by the private, voluntary sector--

- The Robert Wood Johnson Foundation, the Pew Memorial Trust, and the U.S. Conference of Mayors announced in February 1983 a $19.6 million grant program to deliver health services to the homeless.

B. LOCAL GOVERNMENTS

Local governments, often in concert with the private sector, play a major role in the provision of food, shelter, and other services for the homeless. According to the HUD report, about 80 percent of the city and county governments do at least one of the following:

- operate shelters;
- give money to private groups to operate shelters or other services;
- lease or rehabilitate buildings for private shelter providers; and
- provide vouchers to homeless persons for use in hotels/motels/apartments.

In 20 cities surveyed by the U.S. Conference of Mayors in June 1984:

- 90 percent of the cities provided funds to support emergency services, of which:

-- 46 percent came from local revenues;
-- 46 percent from the Federal government; and
-- 8 percent from State government.

- Cities made non-financial contributions such as

-- making available city-owned property to house private emergency service programs;
-- organizing food drives and fundraising activities;
-- establishing emergency hotlines, and
-- undertaking activities aimed at raising public awareness of the problems.

C. STATES

- The States' primary response to the homeless has been the allocation or targeting of such funds as the

-- Social Services Block Grant;
-- FEMA Emergency Food and Shelter Program; and the
-- Community Services Block Grant.

- In a few instances, State funds have been appropriated to provide either social services or shelter for the homeless.

- The National Governors' Association established a Task Force on the Homeless which issued a report in July 1983 describing the plight of the homeless and the relief activities of various State and local governments.

D. FEDERAL GOVERNMENT

The Federal Government's response has consisted of three parts: an interagency task force; special emergency programs; and regular programs.

Interagency Task Force

On October 31, 1983, Secretary Heckler established an Interagency Task Force on Food and Shelter for the Homeless to coordinate Federal food and shelter initiatives; help local groups obtain unused Federal buildings, food, equipment, and supplies; and generally cut red tape for local projects seeking Federal assistance. Its major achievements have been:

- certification of 133 food banks to obtain food from 197 military commissaries; eighteen of them received 100,000 pounds of food from January to April 1984;

- development of an innovative, model transitional housing program in Memphis;

- help in establishing shelter facilities in Washington, D. C.;

- technical assistance to other projects such as a shelter in Seattle and an innovative shelter financing program in St. Louis, Missouri; and

- a workshop for operators of 30 successful projects and, based on this, the preparation of a "how-to-do-it" guide for local groups that is now ready for dissemination to local providers

## Special Emergency Programs

### USDA Emergency Feeding Programs

- Since 1982 the Department of Agriculture has made available more than $1 billion of surplus commodities to help the needy.

- In FY 1983, the Congress appropriated:

  -- $50 million to help pay for the cost of distributing excess foods; and
  -- $75 million to purchase additional, perishable foods specifically for emergency feeding stations.

### FEMA Emergency Food and Shelter Program

Congress appropriated $140 million to the Federal Emergency Management Agency (FEMA) in the last two years for emergency services.

- In FY 1983, $100 million was appropriated with $50 million going to a National Board, chaired by FEMA and consisting of representatives of the

  -- United Way
  -- Salvation Army
  -- National Council of Churches
  -- National Conference of Catholic Charities
  -- Council of Jewish Federations, and
  -- the American Red Cross.

- The remaining $50 million went to the States which distributed funds to local recipients.

- Another $40 million was appropriated for the program in FY 1984; An FY 1984 supplemental appropriation of $70 million was recently approved by the full House Appropriations Committee.

- About one-third of the money allocated through private local FEMA boards in FY 1983 went for shelter purposes, with the remainder spent on emergency food assistance.

## Regular Programs

### Entitlements

Many of the homeless are eligible for Federal and State cash or in-kind entitlement benefits such as:

- o Social Security Disability Insurance (SSDI)
- o Supplemental Security Income (SSI)
- o Aid to Families with Dependent Children (AFDC)
- o Food Stamps
- o Medicare
- o Medicaid
- o Veterans Cash and Medical Benefits

Although there is no way to assess the total dollars received by the homeless under these programs, about 20-35 percent of the homeless do receive some form of public assistance.

Block Grants and Other Programs

A variety of Federal programs can be used to partially support local projects for the homeless or projects to which homeless individuals can be referred for services. Many of these are in the form of grants to States who determine the priorities for their use. Among the more important are:

- o Community Services Block Grant
- o Community Development Block Grant
- o Preventive Health and Health Services Block Grant
- o Alcohol, Drug Abuse, and Mental Health Services Block Grant
- o Social Services Block Grant
- o Low Income Home Energy Assistance Block Grant (for utility costs for shelters)
- o Primary Care Block Grant (also known as Community Health Centers Program)
- o DOE Weatherization
- o Runaway and Homeless Youth Program
- o Section 8 Housing Assistance
- o Community Support Program
- o ADAMHA Research

In FY 1983, $34 million was made available for emergency services under the Community Development Block Grant, and $65 million through the Community Services Block Grant. Much of this went to help the homeless. What proportion of the funds under the other programs was used for the homeless is not known.

## E. OVERALL ASSESSMENT

### Private Sector, State and Local Government Programs

- o On the positive side:
  - -- the response of State and local governments and local groups to the plight of the homeless has been encouraging.
  - -- several promising innovations are evolving:

- food banks
- connection of shelters to other social service providers
- formation of coalitions of service providers
- outreach projects
- transitional housing

o However, additional progress can be made.

More needs to be done to support State and local government and private efforts to:

-- provide health services, which are inaccessible to the homeless in many locations;

-- build shelters, which are not available in some locations;

-- rehabilitate and equip some shelters which are physically deteriorated; some may present health problems; and

-- develop longer-term treatment and support services for the homeless mentally ill.

In addition, State and local governments need to reexamine their judicial, mental health, medical care, and social service systems to ensure that the homeless are not deprived of help because of service discontinuities or inappropriate placement policies.

## Federal Programs

o On the positive side:

-- the block grants have given States flexibility to respond to the problem, and they have used it.

-- the emergency programs, especially the FEMA program, were instrumental in helping many local projects get started.

o However, there are still areas where improvements can be made:

-- Federal efforts to provide surplus Federal property to local groups could be more efficiently coordinated; and

-- the entitlement programs do not work for many homeless persons:

- Most cannot receive food stamps because

a. With the exception of special congregate feeding programs for the elderly, disabled, and abused spouses, food stamps cannot be used for hot meals;

b. if homeless persons reside in a shelter, they are deemed to be institutionalized and are therefore ineligible; and

c. if they are on the streets, they have no place to prepare food and are therefore ineligible.

- Social Security Disability Insurance is available only to those who have work histories.

- Most homeless are single; hence, not eligible for AFDC.

- Supplemental Security Income is available to mentally disabled persons, but they have difficulty applying for and managing their benefits, especially since more are on the streets than in shelters.

- Medicare is only for the aged or disabled workers.

- State Medicaid eligibility rules are often contingent upon eligibility for AFDC or SSI, or even stricter standards, which exclude some homeless individuals.

- Many homeless do not know how to access those programs for which they may be eligible.

## III. STRATEGY FOR A PUBLIC/PRIVATE PARTNERSHIP TO AID THE HOMELESS

### A. OVERVIEW

o Goals

-- Provide emergency care for the homeless

-- Develop linkages between shelters and service providers

-- Provide continuing care for those most in need

o Focus - Concentrate on the:

-- Mentally ill, including those with multiple disorders

(As the service system is improved to help the mentally ill, including those with multiple disorders, other homeless persons will benefit as well. This will result from improved outreach, screening, shelter, feeding, health, and other supportive services, which will benefit the entire homeless population.)

o Responsibility - Collaborative Federal partnership with:

-- State & local governments

-- Private Sector

- business community
- philanthropic & voluntary organizations

o Federal Role - Support Private & Local Efforts Through:

-- Leadership

- Executive Order
- national focus/public awareness

-- Entitlements

- outreach
- remove impediments

-- Technical Assistance

- clearinghouse
- workshops

-- Other Resources

- food
- buildings
- equipment & other supplies

-- Research, Demonstrations, and Training

o Implementation - Three pronged initiative:

-- Immediate Actions:

- Intensive two year effort to match the mentally ill and alcohol abusers with appropriate services and care

-- Long-term Systems Development and Management:

- Long-term development of service linkages and systems management

-- National or regional meetings co-sponsored by one or more of the groups listed below (i.e. The National Citizens Committee for Food and Shelter for the Homeless and/or the National Governor's Association), to coordinate the above activities with the states and other private sector groups, focusing on implemetation, not on the strategy itself. Organizations to involve and/or attend:

- National Citizens Committee on Food and Shelter for the Homeless
- National Governors' Association
- National Association of State Legislatures
- National Alliance for the Mentally Ill
- National Assn of State Mental Health Program Directors
- National Assn of State Alcohol and Drug Abuse Directors
- National Association of County Executives
- U.S. Conference of Mayors
- American Public Welfare Association
- Business Associations
- Churches, Philanthropic Groups
- Consumer Representatives
- Etc.

B. IMMEDIATE ACTIONS

| SERVICE OBJECTIVE | FEDERAL ACTIVITIES TO SUPPORT STATE, LOCAL AND PRIVATE EFFORTS | ANNUAL COST |
|---|---|---|
| OUTREACH | | |
| Help the homeless obtain shelter and services | Workshops, resource guides ..... | $ 1 million |
| | Representative payees ..... | -00- |
| | National Health Service Corps ..... | -00- |
| | Commissioned Corps Officers ..... | -00- |
| | Entitlement outreach ..... | $150 million |
| LIVING ARRANGEMENTS | | |
| Shelters, transitional houses, and group homes | HUD non-marketable housing ..... | -00- |
| | GSA surplus facilities ..... | -00- |
| | supplies and equipment ..... | -00- |
| | Business Community initiative ..... | -00- |
| | Food Stamp and SSI eligibility ..... for transitional housing residents | $ 20 million |
| family foster care | workshops, resource guides ..... | $ 1 million |
| | regular entitlement programs ..... | costed above |
| low-income housing public housing | remove statutory limits on single, non-elderly participants .. | -00- |
| SERVICES | | |
| mental health and other medical care and supportive services | religious and philanthropic group initiatives ..... | -00- |
| | PHS direct services ..... | -00- |

| SERVICE OBJECTIVE | FEDERAL ACTIVITIES TO SUPPORT STATE, LOCAL AND PRIVATE EFFORTS | ANNUAL COST |
|---|---|---|
| INCOME SUPPORT | | |
| cash<br>food stamps<br>housing assistance<br>medical care financing | regular entitlement programs ..... | costed above |
| MANAGEMENT AND COORDINATION | | |
| (overarching activities) | clearinghouse .....<br>public awareness .....<br>UN International Year ..... | $ .1 million<br>$ .1 million<br>unknown |

C. LONG TERM SYSTEMS MANAGEMENT

Longer term effort to reinforce State activities to develop service linkages and management improvements, in collaboration with local governments and the private sector.

RESEARCH

Cost: $1-5 million

Limited to policy relevant projects with clear application at the local level.

- o services
- o systems and linkages
- o programs
- o epidemiology

DEMONSTRATIONS

Cost: $5-10 million

Focus on service linkages, which may include the following types of organizations and services, depending on local circumstances:

| Organizations | Services and Support Systems |
|---|---|
| o Community Mental Health Centers | o Shelter |
| o Community Residential Facilities | o Housing |
| o Outpatient Clinics | o Food |
| o Veterans Administration Centers | o Entitlements |
| o Transitional Facilities | o Transportation |
| o Psychiatric Hospitals | o Mental Health Services |
| o General Hospital Psychiatric and Substance Abuse Services | o Health and Dental Services |

- o Food Providers
- o Shelters
- o Private Sector
- o Social Clubs
- o Judicial Services
- o Correctional Facilities
- o Vocational and Social Habilitation and Rehabilitation
- o Private Sector Involvement (i.e., Projects with Industry)

TRAINING

Cost: $1-5 million

Training programs to be designed by States and carried out by service providers in cooperation with universities and the private sector.

| Trainees | Skills |
|---|---|
| o Shelter Providers | o Entitlements and Referral<br>o Mental Health Volunteers<br>o Identification of the Mentally Ill |
| o Mental Health, Alcohol, and Drug Abuse Providers | o Caring for the Homeless<br>o Improve System Linkages For Better Referral and Care |
| o Self-Help/Homeless | o Access Services and Entitlements and Help Each Other To Do So |
| o Correctional & Judicial | o Identification of the Mentally Ill<br>o Appropriate Referral |

## IV. SPECIFIC OPTIONS

### A. LEADERSHIP: INITIATE ACTION THROUGH PRESIDENTIAL LEADERSHIP

#### 1. Executive Order

Issue an Executive Order to direct all Federal agencies to give top priority to and expand their current efforts on behalf of the homeless.

A Presidential Executive Order and Task Force Charter could be used to strengthen and publicize the commitment of the Administration to make available surplus Federal facilities and supplies, to cut red tape, and to assist local communities to respond to the needs of the homeless. The order would essentially be to carry out the actions described elsewhere in this paper.

(No cost.)

2. Religious and Philanthropic Group Initiatives

Through the direct action of the President or through the White House Office of Private Sector Initiatives, enlist support from the religious and philanthropic community to design initiatives that utilize existing networks of churches, synagogues, voluntary agencies, and public providers to house and serve the homeless, especially the mentally ill.

This might include:

-- having a parish "adopt" one or more mentally disabled persons;
-- sponsoring or supervising operations of group homes;
-- training individuals to serve as representative payees and informal caseworkers; and
-- encouraging and promoting families to provide foster care for the mentally ill.

(No cost)

3. Business Initiative for Facilities

Through direct action of the President or through the White House Office Private of Sector Initiatives enlist the support of business leaders to finance the rehabilitation, equipping, and supplying of shelters and transitional houses for all homeless and community residences for the mentally ill.

(No cost)

4. Public Awareness Campaign

Develop a public awareness program to educate the public, ask for their help volunteering in shelters and soup kitchens; target professional, business and industrial, and political leaders to get their financial support. Provide Presidential or Secretarial recognition of outstanding projects through awards, site visits, speeches, etc. Solicit support of celebrities. The campaign could be directed to the programs for the homeless in general, or be targeted on the mentally disabled.

(Cost: $100,000)

5. International Year of Shelter

Support the U.N.'s International Year of Shelter for the Homeless (1987), and direct the HHS Task Force to work closely with AID (lead agency) in submitting the United States' accomplishments, and developing proposed projects for the homeless.

(Cost: Federal contribution to U.N. operations needs to be determined. However, it would probably be small.)

## B. ENTITLEMENTS: MAKE SURE ENTITLEMENT PROGRAMS WORK

### 1. Eligibility Outreach

Extend the current SSDI and SSI outreach program now functioning in New York City to the 50 most populated cities. Expand it to include food stamps, AFDC, Medicare, Medicaid, and Veterans cash and medical benefits. (Estimates suggest that from 40 to 60 percent of the male homeless are military veterans.) Train shelter operators and clients to assist in initial screening of potential beneficiaries. Promote the use of representative payees to receive and manage benefit checks for those disabled indviduals unable to manage their own finances.

Six Social Security offices are sending a field or claims representative accompanied by a State Disability Determination Examiner to seven shelters in New York City each week on a rotating basis to take applications for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI).

The program has been operating for more than two years, and as a result of Secretary Heckler's personal involvement in the outreach initiative, the rate of eligibility has climbed to over 60 percent.

(Cost: up to $150 million for entitlement payments; 10 FTE's, and $1 million for State administrative costs.)

### 2. Federal Field Office Guidelines

Request each Federal agency on the Interagency Task Force to issue guidelines to their field offices and to State and local government and private sector grantees explaining what special rules apply and what special steps could be taken to adapt entitlement and other application procedures for the homeless.

(No cost)

### 3. Food Stamp Transitional House Program

Allow residents of all transitional houses to be eligible for food stamps and also allow them to be used by the housing project manager to make bulk purchases of food for communal feeding in the transitional house.

Generally, residents of such facilities are regarded as being in an institution and therefore ineligible for food stamps. Exceptions are made for residents of specialized transitional housing with programs for alcohol abusers, abused spouses, and SSI blind or disabled individuals. The proposal is therefore a modest expansion of current programs.

The proposal will promote the development of transitional housing projects.

This will require a legislative change.

(Cost: $10 million)

4. SSI Eligibility for Shelter Residents

Extend SSI eligibility for those living in shelters from the current three-month limit to twelve months. This will provide continued assistance (including Medicaid eligibility) to individuals in transitional housing programs.

This will require a legislative change.

(Cost: $10 million)

5. Section 8 Certificates for Single Room Occupancy Units

Waive the 15 percent limitation on the amount of section 8 housing assistance funds which can be used by single(s), non-elderly clients. This will open up more assistance to the homeless, the majority of whom are single, non-elderly adults.

(No additional cost)

6. Section 8 Certificates/Vouchers for Shelters

Provide that, on a case-by-case basis, Section 8 vouchers for individual units could be issued to emergency shelter providers rather than individual families. Shelter operators could provide short-term, emergency shelter to many families rather than long-term assistance to a single family.

(No Cost)

7. Assisted Housing for Battered Spouses

Provide preferred status for battered spouses in assisted housing programs.

(No additional cost)

C. TECHNICAL ASSISTANCE: PROMOTE PROVEN SERVICE DELIVERY TECHNIQUES

1. Clearinghouse

Establish a national clearinghouse to provide communities a network for sharing information about services for the homeless.

- The system could include such information as the names of all food banks matched with military commissaries; shelter resources available; and model programs to feed and house the homeless that currently exist and could be duplicated elsewhere.

- This can be done through Partnership Data Net in Washington, D.C. which was formed in March 1984 and is supported by HUD, HHS, DoD, private and non-profit organizations, foundations, and community volunteer leaders. It grew out of the President's Private Sector Initiative, and has computerized the "Adopt-A-School" program which matches a school with a private organization or company such as Levi Strauss and Co.

($100,000; the Partnership Data Net has received initial funding from HUD/HHS and DOD.)

2. Workshops and Technical Assistance

Develop an intensive program of specialized technical assistance, including conferences, workshops, and information networks to State or local government agencies or private groups to promote the development of innovative programs and systems for mental health services.

This can be accomplished under authority of section 301 of the PHS Act.

(Cost: Discretionary; $1-5 million.)

3. Family Foster Care

Promote the use of family foster care programs for the mentally ill. This could be done in part through the publication (with a dedication page with message from the Secretary) of a resource guide already prepared by NIMH.

(No additional cost)

**D. OTHER RESOURCES: PROVIDE AVAILABLE FEDERAL RESOURCES TO SERVICE PROVIDERS WHO REQUEST ASSISTANCE**

1. HHS Homeless Task Force Operations

Provide continuing and stable staff for the Homeless Task Force to coordinate and monitor governmentwide activities described throughout the report. Consider establishing a permanent office for the homeless in OS, HDS, or OCS (the latter option only if funds for OCS are included in the FY 1986 budget).

($350,000)

2. Food Banks -- Commissaries

Require DOD and DOT/Coast Guard Commissaries to improve the transfer of nonmarketable food from their commissaries to local food banks.

(Minimal administrative costs to conduct workshops, etc.)

### 3. Federal Facilities, Equipment, and Supplies

Organize more effectively the current efforts (e.g., through an Executive Order) to release surplus Federal buildings, equipment, and supplies to local groups requesting them for projects for the homeless. In particular, obtain from HUD, GSA, DOD, and Farmers Home Administration accurate and complete lists of available properties, periodically updated. More aggressively advertize the availability of all surplus property, equipment and supplies.

(No cost; can be done by current Task Force; however, inventory value of buildings will depend on local real estate values, condition of facility, etc.)

### 4. Memphis/Hud Transitional Housing Project

Replicate the Memphis/HUD project in 10 cities in each region, a total of 100 cities, with special emphasis on designing transitional housing or group homes for the mentally ill.

(No cost; however, inventory value of buildings will depend on local real estate values, conditions of facilities, etc.)

### 5. Extended Leases for HUD Homes

Extend for more than one year the one-dollar leases on nonmarketable but repairable homes which are made available by HUD to non-profit organizations. Under the current program, such homes can be leased for only one year. As a result, the non-profit organizations which sponsor the transitional housing projects may be unwilling to invest in the repairs needed to start the projects or to make commitments to families in the final few months of that year. This proposal would make such houses a much more attractive resource for these projects.

(No additional cost)

### 6. Urban Homesteading Units

Give cities the option to sell urban homesteading units to non-profit organizations for use as shelters, transitional houses, or group homes for the mentally ill. Under the current program, urban homesteading units are sold at a low price to cities by HUD; the cities in turn sell them to individual homesteaders who repair them.

This would require a legislative change.

(No additional cost)

7. PHS Direct Services

Assign National Health Service Corps personnel and PHS Commissioned Corps Officers to work in shelters, provide health screening and referral services in shelters and mobile street outreach teams, and provide support to networks of shelters, perhaps working through community health centers or clinics.

(No additional cost; reprioritizing of current resources)

8. Minimum Health and Safety Guidelines

Direct the Centers for Disease Control to work with State Health Departments to develop guidelines to address health hazards in order to prevent epidemics and cross-infections in shelters.

(No Cost)

9. ACTION Agency Volunteers

Adapt current ACTION programs to utilize public and private volunteers to assist the homeless; e.g., train and assign VISTA volunteers to work with the homeless.

(Cost: $200,000)

10. Shelter Improvements and Operations

Provide Federal funding to pay for part of the cost of rehabilitating and operating shelters.

In November 1983, Congress enacted P.L. 98-181 which authorized $60 million for HUD to make grants for this purpose. No funds were appropriated, however. Instead, Congress appropriated $100 million in FY 1983 and $60 million in FY 1984 to FEMA for an emergency food and shelter program. An FY 1984 supplemental appropriation of $60 million has been approved by the Senate and $70 million has been approved by the full House Appropriations Committee. The FEMA National Voluntary Board has discretion for allocating and regulating funds, which may include rehabilitation expenditures.

(Cost: Discretionary; $60-70 million)

## E. RESEARCH, DEMONSTRATIONS, AND TRAINING: DEVELOP A BASIS FOR IMPROVING THE SERVICE DELIVERY SYSTEM

### 1. General Research

Expand HHS research activities to include projects on the epidemiology and dynamics of homelessness and mental illness; the characteristics of the affected population; and effective treatment interventions, services, programs, and systems linkages. This can be done under current HHS research authorities.

(Cost: Discretionary amount, $1-5 million.)

### 2. Placement Policies

Undertake a special research project to examine State and local government placement policies for the mentally ill to identify the most appropriate and effective means to protect the mentally ill from involuntary commitment while at the same time ensuring accessibility to treatment.

(Cost: $.5 million)

### 3. HHS Demonstration Program

Provide additional seed money to states for innovative service approaches and systems linkages to assist the homeless mentally ill. Systems would be designed to include:

-- outreach programs
-- mental health and substance abuse services in overnight shelters
-- drop-in centers
-- crisis housing
-- health and dental services
-- reconnecting with families
-- case management services
-- long-term rehabilitation, and
-- development of innovative funding sources (including participation of the private sector and encouragement of voluntarism).

This could be carried out through a number of the Department's discretionary programs.

(Cost: Discretionary; $5-10 million)

### 4. HUD/HHS Demonstration -- Housing Vouchers for the Mentally Ill

On a demonstration basis, starting in FY 1986, provide section 8 housing vouchers and mental health and other supportive services to mentally ill individuals. HUD would reserve a fixed number of

vouchers and the related funds for housing assistance to those mentally ill individuals for whom a program of supportive services is organized and operated by a local government or non-profit organization. HHS would provide administrative funds up to a specified limit for organizing the supportive services. HUD and HHS would jointly administer the program.

(Cost: Discretionary)
HUD: section 8 vouchers: $1-10 million
HHS: administrative costs: $.1-1 million

5. Training and Retraining of Mental Health and Related Health Service Personnel, and Social Service Providers

Provide grants to selected schools and State agencies to develop model training programs and to train mental health and related health service personnel and social service providers (including shelter operators) on the special techniques for dealing with homeless individuals who are mentally ill. Current authority is sufficient for mental health training programs.

(Cost: Discretionary; $1-5 million)