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PROBLEMS OF HOMELESS MENTALLY ILL

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH
FOR FAMILIES AND THE UNINSURED

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

ON

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PROBLEMS OF HOMELESS MENTALLY ILL

FRIDAY, APRIL 26, 1991

U.S. SENATE,
SUBCOMMITTEE ON HEALTH FOR FAMILIES
AND THE UNINSURED,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:34 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Donald W. Riegle, Jr., (chairman of the subcommittee) presiding.

Also present: Senators Moynihan and Danforth.

[The press release announcing the hearing follows:]

[Press Release No. H-16, April 18, 1991]

SUBCOMMITTEE TO EXPLORE PROBLEMS OF HOMELESS MENTALLY ILL; "AWAKENINGS" AUTHOR TO TESTIFY

WASHINGTON, DC—Senator Donald W. Riegle Jr., Chairman, announced Thursday the Finance Subcommittee on Health for Families and the Uninsured will hold a hearing on the problems of homeless mentally ill people and legislation to help them obtain health services.

The hearing will be *Friday, April 26, 1991 at 10 a.m. in Room SD-215 of the Dirksen Senate Office Building.*

Witnesses will include Medicaid Director Christine Nye, "Awakenings" author Oliver Sacks, M.D., and former Green Bay Packer Lionel Aldridge.

The bill, S. 62, would require states to establish mobile outreach teams in metropolitan statistical areas to identify homeless mentally ill people and help them obtain psychiatric and other services to which they may be entitled. It also would provide for assessment and referral centers where homeless mentally ill people could get help and would establish a national commission for the homeless mentally ill.

"We are holding this hearing to explore the problems of homeless people who need mental health care services and discuss alternative solutions. One alternative is S. 62, a bill recently introduced by Senators Moynihan and Danforth to provide outreach services to identify, evaluate and develop a plan of care for the mentally ill population that is homeless. Our witnesses for the hearing include formerly homeless persons and experts in the field, including providers and government officials," Riegle said.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN, CHAIRMAN OF THE SUBCOMMITTEE

Senator RIEGLE. The committee will come to order. Let me welcome all those in attendance this morning. This is a very important hearing. Today the subcommittee will explore the problems of homeless people who have mental health care service needs, and to discuss the possible solutions to meeting those needs.

S. 62, a bill introduced by Senator Moynihan who is here with me now, and Senator Danforth, who we expect a little bit later, is one such solution intended to address the needs of this very vulnerable population in our society.

As many as three-quarters of a million persons are homeless on a given night, and somewhere between 1.3 million and 2 million of those people may be homeless at some point during an entire year in our country.

In Michigan, as many as 900,000 people are considered to be homeless during the course of the year. Countless others may be teetering near the brink of homelessness; either one missed paycheck, or personal crisis away from that kind of condition.

It is a disgrace to this country that children are the fastest growing group among the homeless population. More than one-third of the homeless are families with children, and as many as 100,000 children may be homeless on any given night here in America. As chairman of the Senate Committee on Banking, Housing, and Urban Affairs, we designed the National Affordable Housing Act, which also re-authorized the Stewart McKinney Act programs for the homeless.

In addition, this act created the Shelter Plus Care Program, designed to provide rental assistance and supportive services to homeless persons who are mentally ill, have chronic alcohol or drug problems, have AIDS, or any AIDS-related disease.

This week, I offered an amendment to the 1991 budget resolution that was accepted to dedicate almost a billion dollars in new funding for low-income housing. The more dollars that are available for low-income housing, the fewer homeless people we will have.

I will also soon re-introduce the Homeless Outreach Act of 1991. This bill would require the Social Security Administration to reach out to homeless people in soup kitchens, shelters, and day centers, and talk to them about the benefits for which they may be eligible. And it is my hope that Senator Moynihan's subcommittee will hold a hearing on this bill as well.

The hearing today focuses on the specific problems of the mentally ill. Mentally ill persons make up a substantial percentage of the homeless population, ranging from 20 to 40 percent and suffer from such serious mental illnesses as schizophrenia, manic depressive illness, or severe depression. S. 62 would require States to establish mobile outreach teams in metropolitan areas to identify homeless mentally ill people and help them obtain needed services.

It would also provide for assessment and referral centers where homeless mentally ill people could get help, and would establish a National Commission for the Homeless Mentally Ill.

More than ever before, this country needs a national program to provide health care coverage to all Americans. Together with my colleagues on this committee and the Labor Committee, I will soon introduce legislation to provide affordable health care for all Americans, and to control rising health care costs at the same time.

So, this subcommittee intends to hold more hearings this year, and move such a bill forward as rapidly and as far as we can. I particularly want to applaud my colleagues, Senators Moynihan and Danforth, for their leadership in coming forward with a specific plan. I look forward to working with them on their bill to help the homeless mentally ill. Services such as outreach assessment counseling and linkage to more programs is urgently needed. With that, let me yield first to Senator Danforth, then to Senator Moynihan.

[The prepared statement of Senator Riegle appears in the appendix.]

Senator RIEGLE. Let me yield first to Senator Moynihan—graciously, Senator Danforth is yielding to Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Chairman, we first want to thank you for holding this hearing, and to say that it is not, perhaps, inappropriate that a Senator from New York should start the testimony in the simple sense that much of the problem we are dealing with today and groping with as a nation begins in New York. And it is perhaps with just a quick recounting.

In the late 1940's, early 1950's, in New York State at Rockland State Hospital, a great research psychiatrist, Nathan Klein, developed the first tranquilizer, what later generally has come to be known as Lithium. He synthesized the active ingredient in a root that grows in the subcontinent of India called Rauwolfia, and which was used in medicine for years and years to come.

And when Avril Harriman became Governor in 1955, his new Commissioner of Mental Hygiene—whose successor, Dr. Surles, we have here today—came to see the Governor—and I happened to be in the room—and said, we have developed in our hospital research facilities this medicine, and we have tried it clinically, and we think we should try it system wide. And the Governor agreed. What seemed like a large amount of money was involved.

At that time, the largest issue in New York State governance was providing housing to the mentally ill—hospitals. I mean, every year a new thousand bed hospital was opened. From the moment of that decision, the number of the occupancy of our hospitals grew for about 14 months, then crashed—called epidemic curve. It is now 15 percent of what it was 30 years ago, and that has happened around the nation, because this technique spread, and the idea of deinstitutionalization—the term deinstitutionalization.

When President Kennedy came to Washington, there was waiting for him the report of a National Commission that had been established by Congress on this subject. It happens that I worked on the legislation, and the last bill that President Kennedy signed in a public ceremony—the last bill—I have a pen—was the Community Mental Health Center Construction Act of 1963 in late October 1963.

And it envisioned a system in which we would take people—all but the most severely retarded and disabled—out of mental hospitals, but treat them locally through local facilities, not just discharge them. And the proposition was to deal to have one center for every 100,000 people; 2,000 by the year 1980. We built about 450, and forgot what happened.

And then I have said it over and again, that if anybody at that signing ceremony in the Oval Office had said to President Kennedy, now, Mr. President, before you sign that bill, let me tell you that the population of our mental institutions will drop by 85 percent, but we will not build these local facilities. Are you sure you want to sign the bill? And I think he would have put the pen down. What is the matter with you?

In 30 years' time the schizophrenic women in the late middle age will be walking around cities with shopping bags and sleeping on sidewalks. Schizophrenia has an incidence in the population—about half of 1 percent of any large group anywhere in the world will be schizophrenic.

And we are getting very little—the mental health profession is strangely silent. They have a big failure on their hands. They overestimated the power of tranquilizers. They have not been able to make the claim on resources to build treatment centers. They cannot argue the case for consignment of the seriously ill. I mean, there is something called National Institute of Mental Health. Is there?

Senator **Riegle**. Yes.

Senator **Moynihan**. There is, is there not?

Senator **Riegle**. Yes.

Senator **Moynihan**. Yes. Well, I knew there was one 20 years ago, but I have not heard from it in the last 20 years. It is extremely silent out there in Bethesda. The budget is still there, but its voice has been silent. This is a problem for the profession, and I think we ought to help with it. I know that Senator Danforth, who, as a State Attorney, as a pastor, and a Senator is deeply concerned. And we would just like to see if we cannot get the learning process going again here. And I talked longer than I meant, but I just wanted to say that.

Senator **Riegle**. You have provided a very important history. Senator Danforth.

OPENING STATEMENT OF HON. JOHN C. DANFORTH, A U.S. SENATOR FROM MISSOURI

Senator **Danforth**. Mr. Chairman, I thank you for holding the hearing, and I thank all participants for being here, and Senator Moynihan for introducing the legislation.

Today was a typical day in my Washington life. I left my house in Northwest Washington, drove to work, and passed people who were lying on grates; one man on a bench on Constitution Avenue with his belongings surrounding him, and dressed in what appeared to be multiple layers of clothing.

And this is such a common sight now. It is a common sight here in our Nation's Capital, and all over the country. Colonies of people living in little park areas, people who give every appearance from looking at them of being seriously mentally ill, just out there on the streets, and nobody doing anything about it. And I think that this is just manifestly wrong. We cannot have it.

I do not know how many of these people there are. I know that there are estimates. CBO has cited an estimate that in any given week, 700,000 or so people are homeless, and of that number, 30 to 40 percent are mentally ill.

Talking to people in my State, they tell me that the percentage of the mentally ill who are homeless might be somewhat more than that 30 to 40 percent figure. But let us say that at any given time there are, say, 735,000 people, who are homeless. And let us say that a third of those are mentally ill. So that would mean that, say, roughly 250,000—roughly a quarter of a million people at any given time are mentally ill people who are out there on the streets in this country.

Now, if all those people were gathered together in one place so that they could appear on evening news, as say, the Kurds appear on evening news, because they are gathered in one place, it would be a national scandal. People would be saying, "Do something about it." Well, it is no less of a scandal to have these people spread over the country; sick people just out there, nothing happening.

And this bill is very simple. Really, the thrust of it is to say that in each city, somebody should be out there with the responsibility of at least finding the people, looking for them, finding them.

And attempting within the confines of State law, some States provide for involuntary commitment on the basis that a person is mentally ill and needs medical treatment; others do not. My State does not. But at least trying to coax them into someplace where they could be analyzed and put on some sort of program.

I visited a few weeks ago in Saint Louis a place called the Shamrock Center, and here was an organization that does pretty much of this just on a private basis; goes out and finds people. And they say, well, if you give people a candy bar or a sandwich and see them maybe 10 times, and talk to them each time, you get a considerable number of these people who will just come in. And then you can put them on some kind of program. That is what we provide in this legislation, that it be part of Medicaid.

I, myself, do not understand why people who are mentally ill and sleeping on grates are any less in need of Medicaid than a person with some physical ailment. Maybe there is an argument. I would be happy to hear the administration's argument, if there is one.

Senator MOYNIHAN. Could I say to my friend that schizophrenia is a physical ailment.

Senator DANFORTH. Well, that is my understanding, too, that it is a chemical problem, and that it can be chemically treated, perhaps. But the fact of the matter is that you cannot have a quarter of a million people—if that is the number—at any given time in this country who are mentally ill, and who are on the street, and on grates, and on park benches and just say, "oh, well, I am sorry, we cannot do anything about these people." This is a scandal. This really is a national outrage. This has to do not only with a quarter of a million poor souls out there, this is a basic matter of the values of the country. So, I thank you very much, Mr. Chairman, for holding the hearing; and Senator Moynihan, for introducing the bill.

Senator RIEGLE. Well, let me thank your both for your comments, and again, for your leadership on this issue. Clearly, this is one of many pressing national needs. We also have hungry children across the country, and we have other unmet needs.

One of the issues that we face here, is after we reach a consensus, how we are going to pay for it, how the money is to be raised and if it does become an obligation to the States and Federal Government; how do we share this? Certainly, we know how to do it.

As Senator Moynihan points out, this is not a science that we must go and invent. This is a science that we have had now for some decades. So, we know exactly what to do if we decide we want to do it. We know who the people are that need help; we know how to apply treatment programs and assistance programs.

It is simply a question of whether we want to commit ourselves to matching our ability to help with the people who need the help. That is where we are, and what we will hear more about today.

We will be starting out this morning with Christine Nye, who I am very pleased to introduce as our first witness. She is the Director of the Medicaid Bureau within the Health Care Financing Administration. We understand this is your first appearance before this committee, and so we welcome you in this capacity, and we look forward to working with you.

Also we will be hearing from Oliver Sacks this morning, whose experiences with mentally ill people were depicted in the movie "Awakening" starring Robin Williams.

And very importantly, we have Mr. Lionel Aldridge seated in the front row, whom I remember very well from his playing days as a former defensive end with the Green Bay Packers, who played from 1963 to 1971; played on both Super Bowl teams; was an absolutely outstanding athlete during his professional career, but who, himself, was formerly homeless, and will later tell us about some of the experiences that he had to cope with in struggling with schizophrenia. He will discuss how persons can be leading normal lives of an extraordinary sort, and how things can intervene and happen, causing them to become storm-tossed, and not necessarily able to help themselves; in need of others to come forward and help; and to have systems where help can be provided.

Also, we will be having a Michigan witness, Dr. Saul Cooper, who has a long and distinguished career in mental health, and is now director of the Human Services for Washtenaw County in Michigan. I must shortly leave to conduct another hearing this morning in the Senate Banking Committee on some rather urgent matters——

Senator MOYNIHAN. Good luck.

Senator RIEGLE. When I leave, I will ask Senator Moynihan to assume the chairmanship of this hearing.

Ms. Nye, we are pleased to have you. We will make your full statement a part of the record, and we would like you now to make your summary comments to us. Pull that microphone in front of you so that everyone in the room can hear.

STATEMENT OF CHRISTINE NYE, DIRECTOR, MEDICAID BUREAU, HEALTH CARE FINANCING ADMINISTRATION, BALTIMORE, MD

Ms. NYE. Mr. Chairman and members of the committee, I am pleased to be here this morning to discuss concerns about our nation's homeless mentally ill. I was prepared to go through some of the numbers and estimates about the number of, and incidence of mental illness among the homeless, but since that has been gone over by you, I will refrain from that again. But I——

Senator DANFORTH. Let me just ask you, are the numbers correct that we have been citing?

Ms. Nye. The same numbers that you are citing are what I was going to use, but as you know, these estimates are very difficult to come up with.

Senator Moynihan. Why do you not? Let us hear from you. We want to know what you think the numbers are.

Ms. Nye. All right. I will. Estimates of the number of homeless individuals in the United States vary widely. Different studies project that there may be between 560,000 and 735,000 homeless persons on any given night. Approximately one-third of the homeless suffer from mental illness, and about half of these are also involved with alcohol, or other substance abuse. The plight of the homeless and the mentally ill homeless is, in fact, tragic, and deserves our attention.

It is because of this concern that many Federal programs are currently addressing the needs of the homeless population, including those that are mentally ill. Programs within the Department of Health and Human Services, and the Department of Housing and Urban Development assist homeless mentally ill individuals by providing a range of services from food and shelter, to coordination of cash and medical benefits.

Outreach efforts are also under way to insure that eligible people receive the care and services to which they are entitled. We appreciate the concern for the nation's homeless mentally ill embodied in S. 62. However, the bill raises several concerns, which I would like to talk about briefly right now.

Foremost is a concern related to the fact that the program would be mandated for all of the States in this country. As I am sure you are aware, the Medicaid program is consuming increasingly larger portions of State budgets. Recent Medicaid mandates will cost almost $6 billion in Federal/State spending over the next several years.

Our first concern is that given both Federal and State resources are scarce, the administration supports the National Governors' Association resolution that has requested no new mandates. In this fiscal climate, we need to work with States to implement existing programs and determine ways to more effectively use the resources that we now have available to us.

Our actuaries estimate that the cost of this bill, when implemented nationally, could cost up to $1 billion annually. This is a significant amount, given the current fiscal climate that States are facing.

A second concern about S. 62 is that it would expand the Medicaid program beyond its current mission. That is, S. 62 expands eligibility without linking it to any qualifying criteria which define the Medicaid population. Rather, it establishes homelessness in and of itself as the defining criteria for Medicaid eligibility.

Another concern is that S. 62 would target a substantial amount of spending on a relatively small population and, in many respects, may duplicate existing services.

Current activities to serve the homeless fall into two broad categories. Those are services that are targeted specifically to the homeless, and as a subset of those, the mentally ill homeless. And secondly, mainstream programs that are targeted to a more general population in need, which include the homeless.

For example, the Department of Health and Human Services will spend about $232 million in fiscal year 1991 through grant programs targeted to serve the needs of our homeless citizens. The Health Care for the Homeless Program, administered by the Public Health Service, is the largest provider of primary health care to the homeless mentally ill. This program provides substance abuse services, emergency health services, referrals to hospitals, outreach and case management, and assistance in obtaining benefits under other entitlement programs.

There are currently 109 projects in 103 cities in 43 States across the country. In 1989, over 350,000 homeless individuals are reported to have been served by this program.

Another public health service program, the Project for Assistance and Transition from Homelessness, provides comprehensive health services to homeless individuals suffering from severe mental illness and substance abuse disorders. A key feature of this program is the housing assistance options that are provided through it.

In addition to these grant programs, and there are others targeted specifically to the homeless, other mainstream programs also provide support and assistance. One of these is the Medical Assistance program—the Medicaid Program, which our actuaries estimate spends about $200 million a year on services to the homeless.

State Medicaid agencies are required to provide a range of services, including outreach activities and targeted case management services, which are particularly relevant for this population. New York, for example, provides targeted case management under Medicaid to over 5,000 mentally ill who are homeless and live on streets and in shelters.

Another mainstream program, of course, is the SSI, or Supplemental Security Income program administered by the Social Security Administration, which provides cash assistance to low income and disabled individuals, some of whom may be homeless. The mentally ill homeless typically become eligible for Medicaid by becoming eligible for SSI income disability benefits due to their mental illness.

The Social Security Administration has also recently specifically developed a comprehensive outreach strategy to encourage people to apply for benefits and assist them through the application process. Outreach is integrated with community programs, such as in shelters, and with Federal medical, social, and rehabilitation programs.

Another mainstream program is the Alcohol, Drug Abuse, and Mental Health Services Block Grant which provides funds through States and communities, for the development of programs for this population group.

There is also a Federal Interagency Council on the Homeless, which was established in 1987 as a result of the McKinney Act, and is chaired by Secretary of Housing and Urban Development, Jack Kemp. Secretary Sullivan is the Vice Chairman of that group. Sixteen Federal agencies, each of which provide some services to the homeless, participate in that council.

In addition to that, and as an adjunct, Secretary Sullivan has established in the Department a Task Force on the Homeless and Severely Mentally Ill which is currently examining the systemic problems that make severely mentally ill people particularly vulnerable to homelessness. And, he is hoping to have a report to the Interagency Council on the Homeless sometime early next year.

The Federal Government, in summary, is contributing substantial time, energy, and resources to address the important issues and tragedy of homelessness in America. Again, we appreciate the issues reflected in S. 62, but we do not think that this bill adequately addresses some of the concerns I have just expressed.

What we need is a clear picture of the homeless mentally ill, their specific needs, and related services before advancing new funding authorities in addition to those now in existence. I would be pleased to answer any questions you might have about what I have just said, or what I have not said.

[The prepared statement of Ms. Nye appears in the appendix.]

Senator MOYNIHAN. Let me first see if I cannot get it clear. You are saying no to the legislation. [Laughter.]

Ms. NYE. Yes.

Senator MOYNIHAN. Tie. It does not mean no?

Ms. NYE. No.

Senator MOYNIHAN. No. Good. Make you feel better. Just once in the wake of a government—Washington official.

Ms. NYE. On Fridays, no.

Senator MOYNIHAN. On Fridays you can just say what you mean as against what you are going to get written here. So you do not want——

Senator DANFORTH. I have been getting the same answer from the administration on other days as well. [Laughter.]

Senator MOYNIHAN. Let me see. Well, thank you, Ms. Nye, and I certainly am—it is not new for us to have the administration say they do not want to spend more money on something, and maybe that is right. But what I miss—and I wonder about Senator Danforth, and this is not just this administration, but the last four—is I miss any curiosity about what happened. How did this come about? Do you have any idea? You tell us. Now, you are an important Washington official. How did the problem of the homeless come about?

I want you to first of all give us your sources. You say that somewhere between 560,000 and 735,000 homeless people—approximately one-third—suffer from severe mental illness. Why do you think there are three-quarters of a million homeless persons, of whom a quarter million are mentally ill? How did that happen? Was that true 30 years ago?

Ms. NYE. I cannot answer the question about whether it was true 30 years ago.

Senator MOYNIHAN. Well, what did I tell you that you cannot answer the question? Have you ever asked the question?

Ms. NYE. If it was true 30 years ago?

Senator MOYNIHAN. Yeah.

Ms. NYE. No.

Senator MOYNIHAN. You have never asked the question?

Ms. NYE. No.

Senator MOYNIHAN. I see. Has anybody ever volunteered an answer to you? I mean, has anyone come along and said, now, you are in charge of the provision of funds for health care for the poor in this country. Now, let me tell you what a big segment of this group is. And I asked you, have you ever asked what the situation was 30 years ago, and you say you never have. Are you not interested in your work?

Ms. NYE. I have some knowledge of that, because of my involvement as the State Medicaid Director in——

Senator MOYNIHAN. In Wisconsin.

Ms. NYE. In Wisconsin.

Senator MOYNIHAN. Yes.

Ms. NYE. And prior to that, I did have some involvement in working with the disabled in community settings, and was involved with a community mental health center in Madison, WI, which is where I am from. And so I do have some sense about the development of the Community Mental Health Services Act, and the intent of it, and the history of deinstitutionalization in this country, and the development of certain drugs, et cetera.

Senator MOYNIHAN. You know more than you are willing to admit. Do not be afraid of what you know. How many people were in mental institutions in this country in 1960?

Ms. NYE. I could not tell you that off the top of my head.

Senator MOYNIHAN. Well, I brought it up.

Ms. NYE. Could you tell me how many people were——

Senator MOYNIHAN. There you go. Now we learn something. 367,000. That was 30 years ago. And today it is 107,000 on a considerably larger population base. So, I mean, it is very elemental. You asked about the 250,000. You say there are 250,000 persons homeless in a given night who are mentally ill. Well, there are 250,000 persons missing from the population of our mental institutions.

Now, that is only a suggested fact, but it is an illustrative fact. The number of people you say are in this category is almost precisely the drop—the decline in the population of persons in mental hospitals. So we probably—you know, that suggests—look for maybe there is a connection.

And I sympathize with you. You cannot take on more responsibilities, and we understand that. But I wish just once somebody in an executive branch of our government would show that they are interested in what happened. And it is—I wish the National Institutes of Mental Health showed an interest in this subject.

Ms. NYE. In answering "no" when you asked me if I ever asked the question, I should have probably said that I did not ask that question specifically, because I did have some information. And I think it is misleading to say that there is no curiosity about the history and what happened with the homeless. I know it is a topic that has been discussed in the Task Force on the Homeless.

Senator MOYNIHAN. Well, what do they say? I am not going to press you, but I mean, if you say there is—what do they say? What do you talk to each other about when you meet on these task forces?

Ms. NYE. People talk about the incidence of homelessness and mental illness among the homeless; what the break down is in gender; the relationship between mental illness and homeless women, homeless men; the type of mental disorders that are reflected; the type of services that are available, and whether they are appropriately designed to meet this population; the appropriate way to outreach and find these people, to look at these people.

Senator MOYNIHAN. But do they—that was a good question. What would you say was the incidence of schizophrenia in the population?

Ms. NYE. I would say it is probably 2 to 3 percent.

Senator MOYNIHAN. I think you would find it is more like—it is rather stable, at half of 1 percent. But if you think it is six times more than it is——

Ms. NYE. Most of the people I know——

Senator MOYNIHAN [continuing]. You think we have got even more of a problem than we do. And it is interesting that you would, you know, describe the—get the data as best you can. I do not want to keep Senator Danforth from asking, but does everybody not ask themselves, was science overreaching when they said it was a permission bargain that you pay for?

In the 1960's, I know what we felt in Washington; we felt we could get rid of the mental institutions. And I think we might get testimony later today. At that time, Jack, the Veteran's Administration was the locus of our experience and practice in mental care, and there was no national institute. This all came in the 1960's.

In the Veteran's Administration, and I think if I understand, some of the people who are still around from that era feel they had too much of an environmental orientation, because they were dealing with people for whom extraordinary environments had occurred and had over-estimated the capacity for change.

I just wish science would be a little more open. I am not asking you to be, I am talking to that clock up there, behind which there may be somebody observing me from the National Institute of Mental Health. [Laughter.]

Senator RIEGLE. Senator Danforth.

Senator DANFORTH. Thank you, Mr. Chairman. Ms. Nye, thank you very much for being here, and for your first trip before the committee. You have done very well in your—not only as a witness, but in listening to the opening statements of the members. That is one of the great challenges for any witness before any committee, whether you can get through our opening statements, and you have done very well, so thank you.

Ms. NYE. Well, I learned something.

Senator DANFORTH. Do you agree with the basic thrust of Senator Moynihan's question? That is, to let mentally ill people out of institutions and just turn them loose was a mistake?

Ms. NYE. Well, I think that we are right now grappling with the results of that deinstitutionalization process. I do not know that there was any intentional deinstitutionalization with the thinking that people would not receive, at some point, the services that they need.

But we now do have many mentally ill people in our community, and communities across the country, many of them not homeless. And I am not a mental health expert, for sure, but I have been involved as State Medicaid Director in working with some of those communities, and setting up a variety of very different kinds of programs for different communities in dealing with that population.

Senator DANFORTH. Could you agree with me on this, that there are a significant number of people in this country who 30 years ago would have been in institutions, who are not now in institutions, and for whom there is either no substitute care being provided, or very inadequate substitute care being provided?

Ms. NYE. I would say that to some extent that is true.

Senator DANFORTH. Could you speak right into the mike?

Ms. NYE. I would say to some extent that is true. But I also think that you have other witnesses here that have expertise in this area more specifically than I do that would better be able to answer that question.

Senator DANFORTH. All right. There are, under your testimony, perhaps as many as a quarter of a million people who are mentally ill—street people, is that right?

Ms. NYE. The homeless are estimated to be upward of about a quarter of a million.

Senator DANFORTH. On any given night.

Ms. NYE. Right.

Senator DANFORTH. And the mentally ill homeless would be about a quarter of a million?

Ms. NYE. Right. Right.

Senator DANFORTH. Now, do you think that just on its face that that is wrong?

Ms. NYE. Well, I think it really depends on whether those homeless mentally ill people are receiving care, which they can as a homeless individual.

Senator DANFORTH. All right. Let me ask you then a fact question. Are they?

Ms. NYE. Many of them are.

Senator DANFORTH. Many of them. How many, do you know, of the quarter of a million?

Ms. NYE. Well, estimates are that—for example, Medical Assistance, the Medicaid program, serves up to about 20 percent of the homeless. Much of the care for the homeless, in terms of their medical care, is being provided by the Medicaid program.

And the Medicaid program provides care for homeless, primarily who are mentally ill and found to be disabled as a result of their mental illness. That is what makes them Medicaid-eligible. So much of that 20 percent of the homeless, I would expect, that receive care through Medicaid would be mentally ill. Also, there are other——

Senator DANFORTH. Is it psychiatric care they are receiving?

Ms. NYE. Well——

Senator DANFORTH. The 20 percent, or is that just for, say, accident victims, that kind of thing?

Ms. NYE. It could be for accident victims, it could be psychiatric care, it could be——

Senator DANFORTH. So some fraction of 20 percent, you think, may be receiving some care?

Ms. NYE. That is correct. I do not know what fraction that is.

Senator DANFORTH. That would mean that more than 80 percent are not.

Ms. NYE. Well, the 80 percent of the homeless, and what——

Senator DANFORTH. That is what we are talking about—mentally ill homeless.

Ms. NYE. Well——

Senator DANFORTH. You are saying, as I understand your testimony, in excess of 80 percent of the mentally ill homeless are receiving no psychiatric care.

Ms. NYE. I did not say quite that, and it is confusing given that the figures are so indirect.

Senator DANFORTH. Try to correct what I am saying then.

Ms. NYE. All right.

Senator DANFORTH. I have interpreted what you have said as being that in excess of 80 percent of the mentally ill homeless are receiving no psychiatric care. Correct me.

Ms. NYE. All right. The 20 percent is not just the mentally ill homeless. Our estimates are that 20 percent of the homeless receive Medical Assistance.

Senator DANFORTH. I see. In other words, I would interpret that as saying that it is conceivable that zero percent of the mentally ill homeless receive help.

Ms. NYE. Well, another way to look at that is that in order to be on Medical Assistance, you either have to be poor, or receiving a cash assistance program; one of which is SSI. And so that the only way to get on Medicaid is if you are disabled and have a mental disability.

And what I am leading to is many of the 20 percent of the homeless that are on Medicaid, I would expect, would be mentally ill. So that many of the homeless that were not disabled because of a mental health condition would not be on the Medicaid——

Senator DANFORTH. Ms. Nye, can I just—I mean, if the administration has a counter position, fine.

Ms. NYE. Yes.

Senator DANFORTH. That is a position which I will not agree with, but it is a position. But my assertion is that to have a mentally ill person out on the grates is wrong. It is just wrong. Does the administration agree with that, or not?

Ms. NYE. I would think that the administration would agree with that.

Senator DANFORTH. All right.

Ms. NYE. But there are a number of programs that are in place that are trying to deal with this.

Senator DANFORTH. All right. Now let us talk about one that is not in place. Under the laws that now exist, it is my understanding that it is not possible to provide institutional care for the mentally ill who are between the ages of 21 and 65 under Medicaid, is that right? They cannot be treated under Medicaid in institutions.

Ms. NYE. In institutions that are engaged primarily in providing psychiatric treatment, that is correct.

Senator DANFORTH. All right. Now, am I also correct—and then I will just stop asking questions, but just to get the facts—that in the budget reconciliation in 1987, we gave States the option of covering clinic services for the homeless mentally ill in shelters, and other locations, including on the streets. And it is my understanding that while we gave that option to States, the States, in fact, did not utilize the option. Is that right?

Ms. NYE. Not all States utilized that option.

Senator DANFORTH. How many did?

Ms. NYE. There are probably 20 to 30 States that provide clinic services under the Medical Assistance program. I can give——

Senator DANFORTH. Under Medicaid?

Ms. NYE. Correct. And I could give you that——

Senator DANFORTH. For the mentally ill?

Ms. NYE. Yes.

Senator DANFORTH. Specifically for the mentally ill?

Ms. NYE. Yes. And I can check those numbers specifically and get that.

[The following information was subsequently received for the record:]

All States provide optional clinic services which might include services to the homeless mentally ill outside of a standard clinic setting as clarified by OBRA '87 legislation.

Senator DANFORTH. All right. Would you, please?

Ms. NYE. My recollection is that there are 20 to 30 States.

Senator DANFORTH. That have taken advantage of this 1987 exception?

Ms. NYE. Yes. But I——

Senator DANFORTH. Do they have some sort of outreach program to go along with it?

Ms. NYE. All States have outreach programs. Most of the States that provide clinic services have outreach programs.

Senator DANFORTH. All right. So your testimony then is that for 20 to 30 of the States, this legislation is essentially duplicative of what they are now doing?

Ms. NYE. Clinic services are primarily out-patient types of services.

Senator DANFORTH. Right.

Ms. NYE. For people receiving counseling, psychotherapy, intense case management, medication, check-ups, that type of thing. This legislation, as I understand it, would provide more of a room and board type of approach.

Senator DANFORTH. Good, but not necessarily. It would bring people for a month——

Ms. NYE. Right.

Senator DANFORTH [continuing]. Into some sort of setting where they would be evaluated; where they would be put on some kind of a program.

Ms. NYE. Correct. And that part of it is not part of the clinic services under Medicaid.

Senator DANFORTH. Right. All right. Thank you.

Senator MOYNIHAN. Ms. Nye, we want to thank you very much for coming. And if we have seemed to have been impatient, it is not with you, it is with the executive branch over a long period now as we try to get some response on these matters. As I say, it is the lack of just plain curiosity that keeps baffling us. And you are not a clinician. You are an administrator, and you have got a very fine reputation in its own—and you have got years ahead of you. But why do you not go back and raise a little hell in the administration, and say, why in the name of God did you send me up before these two horrible Senators with no information?

I mean, Senator Danforth asked a perfectly fair question, which is now, at this point, 30 years after President Kennedy signed the 1953 legislation, what proportion of the homeless mentally ill are receiving some measure of medical care? And quite properly, you said, well, I do not know. And it is not your job to find out.

There are people who are well paid in this city to learn things like that. As I say, that vanishing National Institute of Mental Health, which may have gone into a deep depression and cannot get its work done; I do not know. But we do not hear from them. They do not tell us this. The Census could work at it. There are resources all over the government that you have a claim on. And to say, in order for me to do my work, I need this information from you.

I just found out there is a man, his name is Louis L. Judd. He is the Director of the National Institute of Mental Health. Have you ever met him?

Ms. NYE. No, sir.

Senator MOYNIHAN. You have not met him. He has not introduced himself? He has not come around and said, I would like to tell you something I think you might be interested to know. It is his failing, not yours. Would you go back and call him up and say this committee would like that information, or would like to know more about his budget and what he is doing with it, quite seriously. And could you respond to Senator Danforth in writing? That is a routine of our committee.

Just help us out by getting us information that helps us judge what you need in the way of legislation. And we would appreciate that very much. We welcome you to the committee, you do not have the easiest job in Washington, and therefore, some of the people who do ought to give you more help.

Ms. NYE. Thank you.

Senator MOYNIHAN. Thank you.

[The following information was subsequently received for the record:]

Relative to Senator Moynihan's question about whether I knew Mr. Judd as the NIMH Director, Mr. Judd is no longer the NIMH Director, Dr. A. Leshner is the director. We have met several times and serve together on the Task Force on Homelessness and Severe Mental Illness.

Additionally, with respect to the number of homeless mentally ill receiving medical care, there are no numbers available to report on this specific population. We do know that the Health Care for the Homeless Program, which links severely mentally ill homeless people with mental health treatment services, served over 350,000 in 1989.

In several studies funded between 1982 and 1986, the National Institute of Mental Health (NIMH) reported that many of the homeless mentally ill population have never received mental health treatment. However, NIMH is not able to report exactly how many *have had* treatment.

Senator MOYNIHAN. And now we are going to hear from a practitioner in this troubled field, a very distinguished neurologist, Dr. Oliver Sacks. Dr. Sacks, I think we saw you arrive just a moment ago, and we welcome you, sir. I see you have arrived with notes, rather than written testimony. That is permitted, and even encouraged. Good morning, Doctor.

STATEMENT OF OLIVER SACKS, M.D., NEUROLOGIST, NEW YORK, NY

Dr. SACKS. Good morning.

Senator MOYNIHAN. If you were to bring—oh, you do have written testimony. Well, we will put in the record as just read, and you proceed exactly as you would like. If you brought that microphone forward a bit, persons in the rear could hear you better.

Dr. SACKS. Mr. Chairman, members of the committee, first many thanks for inviting me here. I should, perhaps, introduce myself first. I am not a psychiatrist, but a neurologist. I have worked for 25 years in New York City in hospitals where the most seriously ill patients reside. Some of these are neurological patients, as in "Awakenings," and some of them are psychiatric patients, as in the State hospital.

I think you have brought out very powerfully the history of deinstitutionalization, the over-estimation of the power of tranquilizers, the under-provision of resources in the community, so what seems such a grand and humane idea in the 1960's has become a sort of disaster.

My own testimony, if this is permissible, speaking from my own experience on the staff of a State hospital for 25 years.

Senator MOYNIHAN. That was Bronx Psychiatric, was it not?

Dr. SACKS. Yes. Bronx Psychiatric Center, which used to be called Bronx State. We deal with some allied problems, which feed in to your own central concern, and which themselves can only increase the number of people outside and on the street. I want therefore to talk specially about an institutional deterioration which I have seen over the past 15 years and now, in this year, with massive cut-backs, the potential collapse of State mental hospitals, which will not only discharge many patients onto the streets, but will remove the institutions to which they might have returned; they may not have any place to be readmitted.

When I first went to the State hospital in 1966, this was at a good time when there were strong therapeutic relationships in the hospital, much one to one psychiatric and medical care, and a high quality of staff. The morale of the hospital was good—and patients often got better.

Since about 1973, I believe, State hospitals have declined, and for many reasons. I think that a major reason has been the notion that care can be done by committee, the replacement of individual physicians by treatment teams, and case managers. Transfer of patients and physicians from ward to ward, unit to unit, has become common in State hospitals. I think that the central idea of care has been lost, to some extent, and that something incoherent and chaotic has been taking its place.

There has also been with this a great demoralization among staff and patients. The quality of medical and psychiatric staff has declined a good deal. There has been a catastrophic loss of good staff. First-class people do not enjoy working in these hospitals the way they used to.

Treatment of patients has become much less effective. With this we have seen, amongst other things, a steady increase in the amount of medication given, often with the many side effects and dangers of heavy medication. We have seen an increase in chronicity, so that patients who would have got better are no longer getting better. Patients, themselves, are not unaware of this, and the rate of self-discharge from hospitals has greatly increased.

There has also been an increasing number of what I am afraid I want to call "drones" in the hospital—medically unqualified people, bureaucrats, who are parts of these increasingly huge treatment teams.

In my own hospital, there has not been a medically qualified director or administration in 12 years, and this is a common situation in State hospitals. I think to some extent these are now run as corporations with large, medically unqualified administrations, who never come to the wards, who never see patients, who do not often talk with the medical staff, and who are out of touch with the realities of patient care and the necessity for continuous, stable, one to one relationships.

In February of this year, something like 1,300 physicians, therapists, treatment aides, and others were laid off in New York State, and further lay-offs are impending. Many other ancillary services, like physiotherapy, have been closed.

About 3 months ago, I was asked to see a patient, a young woman who could not move her arm properly. I was consulted as a neurologist. They said, "rule out neurological disease." I found that this young lady had no neurological disease, but that she had had a broken arm a month before, which had been pinned. She had not had any physiotherapy, because the physiotherapy department had been closed, and the physiatrist had been laid off. This young woman had a severely "frozen" shoulder, and she will be partly disabled by this for the rest of her life.

For me, she stands for the many thousands of patients who are not going to receive adequate medical treatment in these greatly eroded State hospitals. With these present cut-backs, the State hospitals will either collapse, or they will become merely custodial, or there will be a massive discharge of patients—either by the hospitals, or self-discharges.

To conclude, I am intensely conscious with you of the need for outreach services and greatly improved out-patient services of all sorts. But I am equally concerned at the state of the institutions, which I think is quite desperate. And I think at this point I should close. Thank you.

[The prepared statement of Dr. Sacks appears in the appendix.]

Senator MOYNIHAN. Well, Doctor, we thank you, as a person of an international reputation in this field. And you certainly describe a discouraging scene. One of the things that is discouraging, and I can speak of my own State where you have spent a quarter of a century, we have discharged, as it were, metaphorically, we have discharged 85 percent of our patients without at all decreasing the employment or budgets in the institutions where they used to be cared for. And this is an organizational question.

Can I just ask you, did medical judgment change about how to organize a mental health facility? We have had a long experience in trying to work out the institution, from Erving Goffman in our time, back for a century and a quarter now, how institutions behave, and how they care for the medically ill, has been a subject of a great deal of inquiry, and a fair amount of very good writing. I mean, did something happen? I mean, I remember you spoke of the early 1960's, the vibrant sense—I can speak of the 1950's when Paul Hoak and Nathan Klein were alive, and had, perhaps, too much optimism. But there was a lot of energy in the system. Are we dealing with the second law of thermodynamics here?

Dr. SACKS. I think the 1960's may have been a particularly good time, to some extent. The 1950's and before that was the time of snake pits, and, of course, Goffman's book on asylums presents a rather terrifying picture of institutions. I am not as knowledgeable as I should be about medical and sociological models. I am conscious that things have been happening all around me.

But obviously, one needs much knowledge beyond a clearly clinical or psychiatric knowledge. You have to know about the whole life of the person, and you have to have a good social grasp. I think, obviously, physicians are not enough. But it seems to me that there has been sort of sociological and other models which have come to replace the medical models, to some extent, replacing doctors themselves. And—this may be my own chauvinism—but I do not think that a central relationship with a therapist can be replaced. I think there has to be a one to one relationship with patients.

Senator MOYNIHAN. And you have said earlier that we ought to at least consider the proposition that we over-reached in our expectations in the 1960's, that deinstitutionalization could—there was a pharmacological response that could handle all that.

Dr. SACKS. Right. Well, I have had quite a lot to do with wonder drugs of another sort, with L-Dopa and my Parkinsonian patients. But there was, as you say, enormous and exaggerated optimism, I think, about Thorazine, and the other tranquilizers.

It was thought not only that they could treat all symptoms, but that they might alter the natural history of schizophrenia. And I think it is clear that they do not do so. Some of the negative symptoms of schizophrenia, such as social disability and apathy, are not altered at all by tranquilizers.

Senator MOYNIHAN. Senator Danforth.

Senator DANFORTH. Dr. Sacks, thank you very much for being here. When Senator Riegle was here, I do not know if you had come in, or not. But he raised the question that we always raise about any proposal for legislation, and that is, how do we pay for this?

Now, what is interesting to me is that you have described a change between the 1960's and today. We did not have Medicaid in the early part of the 1960's at all. There was not any such program. Medicaid was not passed until 1965. And yet, we had provided care for people who were mentally ill. We did not just let them roam the streets, did we? We are spending more money on health care; everybody knows that.

But manifestly, we are not doing as good a job as we used to do for these people. How could it be that in the days before Medicaid we provided for these people, and today when we are looking at an outreach program that says make contact, try to get the people into someplace where they could be diagnosed and put on a program, we say oh, that is too expensive. I mean, what has happened? Clearly, it is not just a money problem.

Dr. SACKS. No. I think there would be enough money—perhaps more than enough money, but certainly enough money—if things were efficiently organized. As you said, Senator Moynihan, the hospitals now only have 15 percent of their inpatient population, but they are costing what they did in the 1960's. I think there is obviously some sort of huge wastage of money one way or the other.

I should have made clear that I think there have been somewhat similar changes with the out-patient organizations. I know, again, with my own hospital at Bronx State, that it had five out-patient clinics in the early seventies, and it is now down to one clinic. And patients are continually lost to follow-up. When they are lost to follow-up, they often stop taking medication and end on the streets.

Senator DANFORTH. How can it be that we had enough money to provide institutional care. We had enough money to provide for follow-ups. We had enough money to provide one for one care for these people before there was any such thing as Medicaid. And now HCFA says that we do not have enough money to provide even for an effort to find these people on the street and take them somewhere just for a short period of time. How can that be?

Dr. SACKS. Well, I do not know, but this is certainly something which needs to be clarified. And the money is going somewhere, and I think it must be going to useless, rather than useful ends—possibly to support a huge and useless bureaucracy.

Senator DANFORTH. But I have always thought that the most expensive care is institutional care, and we decided to let these people out of institutions, and now we say oh, I am sorry, but with Medicaid, which was not existing when they were in institutions, we do not have enough money to provide for doing what we did before there was any Medicaid. Am I making myself—is the question clear?

Dr. SACKS. Yes.

Senator DANFORTH. Senator Moynihan, I hope I am not divulging a confidence, but he just whispered in my ear, "It is a scandal." I mean, do we have people who are taking the dollars available and just rolling it on something scandalous?

Dr. SACKS. Well, again, I need to say I am afraid that I am very ignorant of fiscal and administrative affairs. I tend to see my patients, and to be immediately and rather concretely concerned with seeing patients, and with how patients are seen. I do not know what is happening.

I do know that at the present time, very large numbers—tens of thousands—of seriously ill mental patients require hospitals which will provide long-term hospitalization either continuously, or intermittently, and that city and university hospitals do not do this; only State hospitals do it.

I know that State hospitals are a needed resource, and that they must not vanish. I also know that they have become grossly costly and inefficient, and conceivably corrupt; I do not know. The challenge is to try to make them less costly, and more efficient, and in every way better. But I can only speak in rather general terms.

Senator DANFORTH. I asked Ms. Nye, testifying for HCFA, whether she would agree, or the administration would agree that to have somebody mentally ill out on a grate is clearly wrong.

Now, I guess the only way that it could be right—I do not know—but it seems to me the only way that it could be right is to say, well, these people are somehow being tended to. I mean, there is some sort of care that is going on.

Do you think that for people who are mentally ill and on the streets on benches and grates—some quarter of a million may be in this country—do you think that there is any reason to believe that they are receiving adequate care? Let me put it this way. What quality of psychiatric care, if any, do you think that they are receiving?

Dr. SACKS. I would think that those who are on the streets are receiving virtually no care; that one way and another they have fallen through the support system, or the support system cannot accommodate them. And although there will always be a handful of odd and eccentric people on the street—and this has always been part of the structure of society—this huge problem now is clearly because the care system is grossly inadequate.

Senator DANFORTH. Thank you.

Senator MOYNIHAN. Doctor, I would take it, without asking that you know the specifics of the legislation that Senator Danforth and I have introduced, that you would be generally supportive of the proposition that a person found in the condition that suggests a mental illness, ought to be brought to a facility and diagnosed. And if diagnosed in those terms, ought to be provided for.

Dr. SACKS. Oh, absolutely. All of us every day see these people on the street, and the first thing is to reach out and to have the capacity to reach out, and to have referral and assessment centers, and to do something.

These people on the street are not resistant to therapy. Most of them want it. And they need it, and they know they need it. I think that what you suggested is urgently necessary and lacking. But I simply want to add to this my own concerns that there should also be decent institutions if and when they are needed.

Senator MOYNIHAN. If people need institutions, they ought to be effective ones. The point we are trying to—and you are very thoughtful about your profession. Something happened.

For instance, Senator Danforth and I will speak of our having emptied out our institutions. Well, of course, this process began such a long time ago, the people who might have been discharged are probably—are no longer living. It is just people are not entering institutions.

I said at the outset that I was present at the meeting in the Governor's office in Albany when Paul Hoak described what I think we came to know as Lithium, which developed at Rockland State by Nathan Klein, and proposed that it be used system wide. The clinical tests were such.

And from that point, the population of our institutions followed an epidemiological climb, and then crashed in that manner, and it has never come back. We assumed we would be treating these people.

In 1963, the last bill John F. Kennedy signed in a public signing ceremony was October 23, 1983. He signed the Community Mental Health Construction Act of 1963. He gave me a pen, and I have got the pen. And I think if we said to him, you know, Mr. President, before you sign that bill, could I tell you that we are not going to build 2,000 community mental health centers, we are going to build 450, and then forget we got started.

I think he would say, listen, do not be silly. We will end up with schizophrenic persons sleeping in doorways. I mean, it is not the best that they be in institutions, perhaps, but it is better than living at Grand Central Station. Somehow, we have to retrieve the memory that we put in place a process which we have not completed, or has not worked. Do you not feel that?

Dr. SACKS. Yes, I certainly agree with you that if Kennedy had known that the support would not be available in the community, then the present situation of this 2 or 3 hundred thousand homeless people might have been foreseen, and would have been forestalled, perhaps.

I think there may be occasional rare communities—I think Santa Cruz is one of them, in California—where there have been adequate building of centers and care. But this is pretty rare. No, we should have prognosticated this 30 years ago.

Senator MOYNIHAN. Now, if we did not do that, at least we could reconstruct the experience. And that is why, if I can say, and that is not a particular obsession of mine, but the National Institutes of Mental Health are supposed to have something to say about this, and they are silent.

The one last question of your—if that is all right with you, Senator. We have seen new sources of mental illness in our time. I mean, I think we take it as a large body, the largest group of patients will have just a natural predisposition to certain kinds of mental illness, and certain stable incidents.

But, for example, crack cocaine appears as a mutant of cocaine in 1066 in New York. It appears in the Bahamas in 1965. It was coke science. It was produced in a kitchen somewhere in the Bahamas. Dr. Allen has written about it in "The Lancet" in 1966.

Now, that is giving you problems of psychotic episodes and depression, and then children come along. Can you tell us something about that from your own personal experience?

Dr. SACKS. Well, I tend to see perhaps relatively more of the neurological damage which can happen with cocaine and other drugs. Cocaine can send the blood pressure sky-high. This can lead to cerebral hemorrhages, strokes, heart trouble. Cocaine can kindle seizures, which may then continue. Cocaine can lead to a dementia. And, as you say, it can also precipitate acute psychoses, which may go on for many months, and severe dependency and withdrawal States.

I know certainly at the State hospital we not only have a large alcoholic rehabilitation unit, but a new population of younger drug-addicted people who are added to the traditional population.

Senator MOYNIHAN. Yes. Well, sir, the committee would like very much to thank you for—it is not easy for you to leave your practice and come here. Your reputation precedes you, and the mind of this

Senator is advanced as you leave. We hope you will stay in touch with us, and give us your counsel. We need it. Senator Danforth.

Dr. SACKS. Thank you very much.

Senator MOYNIHAN. Thank you, Doctor. And now we have a panel of persons working in this field. First of all, Mr. Lionel Aldridge, who was introduced earlier by Senator Riegle. And he will be accompanied by Tom Posey, as President of the National Alliance for the Mentally Ill. There you are, Mr. Posey.

Dr. Saul Cooper, who is director of the Washtenaw County Department of Human Services in Ypsilanti, MI. Dr. Cooper, we welcome you, sir. And Dr. Gary Morse, who is the director of the community support systems for the Missouri Department of Mental Health. Dr. Morse. Did I get it right? Missouri?

Dr. MORSE. Missouri or Missouri.

Senator MOYNIHAN. Oh. Do not say that in the presence of Senator Danforth. It is Missouri.

Dr. MORSE. I defer to the Senator on the——

Senator DANFORTH. Believe me, I have got friends on both sides.

Senator MOYNIHAN. You have got friends on both sides. I think we will proceed in our normal practice by the listing in the panel. So Mr. Aldridge, welcome, sir.

STATEMENT OF LIONEL ALDRIDGE, MILWAUKEE, WI

Mr. ALDRIDGE. Thank you. Mr. Chairman, members of the committee, I am a paranoid schizophrenic. I got that diagnosis back in 1974 when I started having some early symptoms of the illness. My early symptoms were becoming very suspicious of people, difficulty completing tasks on time, and difficult to work with.

So I got myself into a therapy program, and soon after getting into therapy I had what is called a psychotic break, which is a complete break with reality, and had to be hospitalized. And that is where I got the diagnosis. At the time, I was working as a sports announcer in Milwaukee with a radio and television station, and I continued to work in that capacity until 1981.

In March of 1981, I left the job and lost my home on the same day, because my wife had started divorce proceedings because of a number of things surrounding the illness. I still had some resources, so I did not wind up on the street right away. I could like with some relatives, and support myself in some ways for a brief period. But by the time I wound up on the street, I was in Florida, and it was during the winter. I figured if I was going to go on the street, I was going to go someplace warm, especially during the winter. So I went to Fort Lauderdale, a place I had been to on vacation.

At this time, I had not received any kind of treatment for the illness, because while I was still working and was mentally ill, I had refused to accept the treatment. And 2½ years or so that I spent on the street, I was not approached at any one time by anyone offering me any kind of treatment. I eventually made my way back to Milwaukee, where I live, and was taken to a hospital by a former business partner and friend of mine.

Once in the hospital, I agreed to accept treatment, and the medications worked right away. The voices stopped, the hallucinations stopped, and the paranoia was beginning to subside. So I got really excited about the possibility of getting well, and I became completely cooperative in the hospital.

I started some coping skills, some self-help techniques that I thought were beneficial in helping me to get out of the hospital, but when it became time for me to be released from the hospital, they could not find housing for me because of my age; I was in my early forties. So they could not find a group home that would take me. So they sent me to a nursing home.

I went to the nursing home and spent a full month there. But while there, someone from Social Security came around and helped me complete the paper work and got me on Social Security.

Someone else came around and asked me if the National Football League knew that I was in this condition. So they contacted the League office and got me on disability, and suddenly, I was sitting in a nursing home with $20,000 in the bank, and getting about $1,700 a month. And with those kinds of funds, I could afford my own apartment. So I moved from the nursing home to a basement apartment with the Salvation Army.

My first job was guarding the parking lot, because the Salvation Army was an elderly feeding site, and this neighborhood was kind of rough. So while they were in eating, sometimes they would lose the batteries from their cars. So my job was to guard the parking lot while they were eating and to keep their batteries from being stolen.

But before I left the nursing home, someone from the Division of Vocational Rehabilitation came around and asked me if I would like to go back to work. So they got me a job as a mailhandler with the U.S. Postal Service. And once I went to work, my health improved tremendously, once I had something to concentrate on for 8 hours a day.

But I suppose the main thing I would like to say about being homeless is that once you are on the street, you cannot get off by yourself; you have to have help to get off. I remember being in Sidney, NE and being physically ill, and walking into the hospital in that town, and the temperature outside was below zero. And I asked for some kind of treatment, but I was refused treatment because I did not have any kind of insurance, or any kind of resources, and was told that I needed antibiotics, and that I should go down to the drugstore, and they would phone in a prescription down back in town. I went back in town to the drugstore, only to find out that I would have to pay for this prescription, and I had no money to do that.

So I went to the police, and the police gave me a voucher for a couple of cans of soup, and got me a room for a night. Well, I was really ill by the time I got to that room, and I was perspiring a lot and shaking all over. And I asked the manager of that rooming house to help me.

So he went back to the police, got them to pay for the medication, and got me two more nights at the rooming house. So that was probably the extent of any services that I received in the 2 years plus that I was on the street as a street person.

Senator MOYNIHAN. Sir, that is an extraordinary statement, and I know we will want to continue this conversation. But your point that people on the street need someone to reach out—need someone to reach out to them. But we will now hear, I think, from Dr. Cooper, and then we will hear from Dr. Morse, and then, Mr. Posey, you want to say something, we will be happy to hear from you, sir. Dr. Cooper, good morning.

STATEMENT OF SAUL COOPER, M.A., DIRECTOR, WASHTENAW COUNTY DEPARTMENT OF HUMAN SERVICES, YPSILANTI, MI

Mr. COOPER. Good morning. Thank you very much for the opportunity to testify regarding this extremely importance piece of legislation.

Senator MOYNIHAN. If you would pull that a little closer, sir, so people behind can hear you.

Mr. COOPER. Thank you. The bill clearly addresses a major unmet need in mental health services, and does significantly address at least some of the complex problems we, as practitioners, face. Before I comment on various aspects of the bill, I would like to introduce myself briefly, if I might.

I am a psychologist, and my career in mental health began 40 years ago as an attendant at a State hospital. During my first day on the job I was handed a baseball bat by my supervisor, and I was naive enough to believe that the ward I was assigned to had a recreation program.

Since that time, I have become much less naive and much more experienced with regard to the problems of persons that are homeless and mentally ill. I have served in a variety of capacities in mental health centers both in Massachusetts and in Michigan, and was, for over 15 years, the director of a community mental health center in Washtenaw County.

Presently, I am Director of Human Services for this county, and I am actively involved in attempting to integrate several different Human Service programs so that we can truly deliver "one stop shopping" not only for homeless persons with mental illness, but also for other consumers of services.

Community mental health programs today are far from adequate in meeting the needs of many of their clients, and especially persons that are homeless and mentally ill. Our center, like most, has had to eliminate services for the less severely ill; has had to eliminate consultation services; and most unfortunately, all of their prevention programs.

The population we serve are essentially without resources and have a multiplicity of economic, physical, and psychological needs, and our center has extremely limited resources to respond. Much has been said about why community mental health programs have failed to meet their promise of 1963. I would like to add my own impression, that many State and local programs were supported neither by the local citizenry, nor by the political process in seriously addressing the most chronically impaired populations. That, in part, helps to explain what happened. I believe that in most States there is a continuing and increased commitment to this population, and that the passage of Public Law 99-660 further enhanced this focus. The majority of mental health programs in this country are, in my opinion, committed and prepared to respond to the homeless mentally ill, but the lack of resources is a major obstacle.

Much has been written in the media about this population. We hear that all the homeless are mentally ill; that they are all perfectly content to live in the street; that they are all substance abusers; and that most of them are capable of self-sufficiency if only they had the strength of will. I am sure the committee members know that none of these perceptions fit reality from the point of view of we practitioners.

We have learned a good deal from the NIMH-McKinney service Demonstration Projects and we believe that we do know how to serve this population. What we need is money, not demonstration projects. And we believe that S. 62 would provide a significant step in the right direction.

I would like to comment just briefly on several sections of the bill. This population is diverse with a variety of clinical presentations and personal stories. The bill's emphasis on an individual treatment plan recognizes that people do not end up among the homeless for the same reasons, and therefore, the approach to addressing their problems must be based on looking at the complexity and the status of each individual.

Our projects in Michigan for persons who are homeless and mentally ill have shown us that community mental health programs could serve many more chronic mentally ill persons if they had the resources for more supported independent housing; more intensive case management and more daytime psycho-social rehab services. Such resources would enable community mental health programs to offer clients meaningful choices about living arrangements and support services.

In terms of our own experience in Washtenaw County, we have been providing outreach to this population in excess of 5 years primarily at our shelters. And in so doing, we have learned a great deal.

The first step that outreach represents that we have learned is one of engagement. Of building trust by meeting the client on his or her own terms—and by the way, on his or her own turf. If this step is missed, the treatment plan will not stick. We are still learning. We have much to do to improve how we serve these people. But building on what we, and others have learned, and what we have done, would be much more efficient and cost effective than starting all over again with a significantly new service model.

I would like to say a word about section 3A on the involuntary transport. While "involuntary transport" might well be useful under limited circumstances, unless a person appears to meet commitment criteria, we do not, and cannot in Michigan, transport on an involuntary basis. I believe that is also true in a number of other States. The bill would not supersede State commitment laws, so, it is not clear how this would work.

Transport and acute psychiatric care, in our judgment, should be reserved for people having acute psychiatric crises; many homeless persons with mental illness, while in dire need, do not present acute symptoms. And we believe this approach would overload and immobilize precious psychiatric emergency resources.

Again, I would stress that the approach is incompatible with what we have learned about the type of outreach that does work. And that brings the point of contact to the client and builds a trust relationship so they will continue to participate.

A final point about involuntary transport. This approach unfortunately, in our judgment, will quickly teach homeless people and shelter providers not to trust or to talk to outreach teams, and that would undermine their outreach effectiveness.

I would like to say a brief word about affordable housing. Safe, permanent, affordable housing with flexible supports is the overarching need in most communities. It is extremely difficult to find, and even harder to hold onto. This is a major area of frustration for outreach workers.

A housing development effort at the community, State, and Federal levels is required. The withdrawal of Federal housing support over the last decade was a major contributing factor to the homelessness we now confront.

There are local initiatives at housing development which we see as painstaking "points of light." However, they are often supported by private sector groups on shoestring budgets. As long as these "points of light" are surrounded by Federal darkness, they will burn themselves out in the futile effort to keep pace with an expanding homeless population.

The bill assumes 90 days would be sufficient to identify, evaluate and develop a meaningful treatment plan. In many cases, it is not likely to happen and be a plan that "sticks" over the longer haul because of a lack of available treatment resources. Medicaid coverage for the comprehensive treatment and support services necessary for this population is severely lacking throughout this country.

Furthermore, reimbursement through Medicaid is often tied to an MD's signature on a treatment plan. However, before a homeless person ever sees a psychiatrist, there is a lot of service overhead that goes into working with them. That overhead, all the outreach, all the evaluation, is not a covered expense in many of the Medicaid programs, and we urge you to look at that.

Finally, I would applaud the establishment of a National Commission for the Homeless Mentally Ill. I would applaud the mission and the functions that you have mentioned in the bill. And all of us professionals look forward to success in your efforts as represented by S. 62, and we thank you for doing so.

[The prepared statement of Mr. Cooper appears in the appendix.]

Senator MOYNIHAN. Thank you, Mr. Cooper. And I thank you, in particular, as one of the nine people in America who has read "Maximum Feasible Misunderstanding." It is in the testimony somewhere there. I failed to note for the record that Mr. Cooper is here representing the National Council of Community Mental Health Centers, and so your testimony is all the more welcome on that score.

Mr. COOPER. Thank you.

Senator MOYNIHAN. And Dr. Morse.

STATEMENT OF GARY MORSE, PH.D., PSYCHOLOGIST, DIRECTOR OF COMMUNITY SUPPORT SYSTEMS, MISSOURI DEPARTMENT OF MENTAL HEALTH, ST. LOUIS, MO

Dr. MORSE. Thank you. I am pleased to speak before this committee, and although you have already heard moving testimony from Lionel Aldridge, I would like to introduce you to another American, Mr. C, who also suffers from mental illness.

Mr. C. is a middle-aged black man who, despite frequent hospitalizations, has spent about 8 years of the last decade in shelters and on the streets. But I think he is best introduced by two images.

The first time I met Mr. C., he was sprawled across a sofa at the shelter. His arms and hands were contorted, and stuck out to the side. Mucus and food crumbs were smeared across his face, and he accidentally spewed spit onto my face as he tried to panhandle me.

The second event begins 18 months later at a holiday picnic and softball game. Mr. C. arrived with his outreach case manager, wearing clean slacks, a sports shirt, and a red, white, and blue fisherman's cap with 1984 Olympics, Los Angeles on it. He was grinning and talkative during the picnic, but he grew serious during the softball game. As I watched him crouching at first base staring intently at the batter, I thought that the transformation from the first time I saw him was almost surreal. It reminded me of a movie I saw at that time, "Field of Dreams," which was a wonderful movie about Shoeless Joe Jackson, and more about being able to play out unfulfilled dreams on the baseball field.

For now though, I will veer away from the national pastime to one of America's most pressing domestic problems. Mr. C. is one of approximately 1 million Americans who are homeless each year. Somewhere between 250,000 to 400,000 homeless people suffer like Mr. C. from a major mental illness.

They also have many other pressing needs, including permanent housing, employment, financial assistance, and even for basic safety, since about one in four is beaten or robbed on the streets, and one in seven of the women are sexually abused.

What is disturbing is not only this high level of need, but the lack of help. Only about one in five is receiving help for housing or employment, and only 15 percent of the homeless are receiving mental health services.

And yet, contrary to stereotypes, 97 percent of the homeless indicate a willingness for help for housing; 93 percent for employment; and 84 percent of those with severe problems State a willingness for mental health services.

Outreach and case management are essential mental health services for the homeless. They are time-intensive, but they are important ways to build trust, to communicate caring to those who have been forgotten, and to help clients learn to cope both with their illness, and with the maze of often unresponsive bureaucratic systems on which they must depend for basic resources. New research also shows they can be very effective.

The study found that the clients of an outreach and intensive case management program—the CASA program in St. Louis—in sharp contrast to the myth that the homeless cannot be helped, improved significantly over 1 year's time in a number of areas, including decreasing their psychiatric symptoms; increasing income; improving interpersonal judgment and self-esteem; and most importantly; decreasing the time homeless; and increasing time spent housed.

The positive results are not limited to the single research program. From programs across the country, it is clear that homeless mentally ill persons do improve when provided with sensitive and skillful service and appropriate resources.

Now, the differences that we make may be less dramatic than the stunning reversal for the patient shown in "Awakenings," the wonderful moving stemming from Dr. Sacks' work. And yet, it is still significant that in the CASA program, homelessness decreased from 100 percent to 14 percent of the clients over 1 year's time. Further, the improvement in the quality of human life can also be marked, even if perhaps it is too subtle to measure scientifically.

I think of Mr. C. again, standing at first base, with his red, white, and blue Olympics cap on. You know, Mr. C. talked about being a good ballplayer when he was young, but his career was cut short, like Shoeless Joe Jackson's, but for a very different reason, that of mental illness.

Still, he was able to play softball that day. And during the middle of the game, there was a pop up near me. I lost the ball momentarily in the sun, and as I was circling around, I heard a thundering of feet from behind, and an "I got it" yelled out.

I notice that despite improvements, Mr. C. has unmet needs, for example, for a job, and improved hygiene. He is not one of our most successful clients, indeed, he is one of our most challenging.

But at that moment, those issues were lost like the softball in the sun. When the ball came down out of the sun, there is a moment that was hard to describe, but it was special, almost magical. As the ball came down, Mr. C. streaked across the field, his arms and hands which are so often contorted with tardive dyskinesia outstretched and catching the ball, playing the game in his own filed of dreams, with all the grace of a Shoeless Joe Jackson.

The opportunity to live such dreams is still far from a reality for the vast majority of mentally ill homeless people in America. It is clear that the level of services provided, despite what you heard earlier this morning from the administration, still falls so far short of the need, that my words are similar to yours, it is a scandal, "a scandal of disproportion."

For that reason, and because of the many positive features of the bill, although some clarifications and cautions may be needed, I strongly endorse Senate Bill 62. Thank you.

[The prepared statement of Mr. Morse appears in the appendix.]

Senator **Moynihan**. Thank you, Dr. Morse.

Senator Danforth, why do you not begin the exchange with our panel.

Senator **Danforth**. Thank you, Mr. Chairman. Mr. Aldridge, you spent 2-plus years on the street, and you mentioned that you began this in Florida. And then you have also mentioned you were in Nebraska for a time. Were you in several places during this 2-plus years?

Mr. **Aldridge**. I was in many places. I did not come east of Chicago, but I was in just about every other State, because I was trying to stay in the shelters that were available in the cities. And in the shelter, you either get one to five nights at any single place, and then you have to move on. So I would hitchhike to a different city and get a new set of days, or sleep out.

Senator **Danforth**. Or sleep out.

Mr. **Aldridge**. Yes.

Senator **Danforth**. So some of the time you were literally on the street?

Mr. **Aldridge**. Oh, much of the time, yes.

Senator **Danforth**. Much of the time.

Mr. **Aldridge**. Yes.

Senator **Danforth**. And during that time there was no offer of help, there was no kind of outreach to you at all?

Mr. **Aldridge**. Not at any time.

Senator **Danforth**. And I would imagine during this time you came in contact with a good number of other people as well who were in the same situation.

Mr. **Aldridge**. Other homeless people like myself, yes.

Senator **Danforth**. You are not a professional in the mental health field, but just from your observation of them, would you imagine that a fair number of them had some sort of mental illness?

Mr. **Aldridge**. Yes, I would, because the symptoms—those that are really acting out are pretty obvious. When people are hallucinating and talking back to their voices, that is a pretty obvious symptom of some kind of a mental illness. And that was quite prevalent out there.

Senator **Danforth**. Do you have any way of knowing whether these people benefitted from any kind of an outreach program, or anybody was trying to help them?

Mr. **Aldridge**. I do not know of any kind of a program. I think if there had been some kind of a program I would have known about it, because I was in—you only have to be in one place long enough to know what is going on. You do not have to be there very long to know if some kind of help is being offered. And I am not aware of anyone else out there who was offered any kind of assistance.

Senator **Danforth**. Now, Mr. Cooper and Dr. Morse, Ms. Nye, for the administration, catalogued the things that are being done now, and there are some outreach programs, in St. Louis, for example, Dr. Morse. Is it your testimony, though, that whatever is being done now is not sufficient, and if so, in what way is it not sufficient? And what, generally, should we be trying to do about it?

Dr. **Morse**. I think it is clearly not sufficient. I think that since the McKinney Act there are more services for homeless mentally ill people than there had been, and that is a step in the right direction. But the level of service provided still falls far short of the need.

I think the sorts of things that need to be done include outreach and case management, and that way I see this legislation as one important first step in that direction.

I think there needs to be also in tandem with that supportive services, intensive case management, which will work with people on an ongoing basis. And that is being developed in a number of States but that is clearly needed.

The mental health system needs to be in some ways still restructured so it is more accessible, more flexible to these individuals who are not being well-served. There also clearly, I think, needs to be more housing for individuals as well.

Senator DANFORTH. Mr. Cooper.

Mr. COOPER. I would support everything that Gary Morse has mentioned, and add a point or two of emphasis. It would be extremely valuable if we could have dedicated Section 8 vouchers for homeless mentally ill. I emphasize it in my testimony.

We compete for those vouchers with a large population group, and the ability to move a homeless person into a stable psychological environment is very much dependent on moving him into a stable living environment physically. And without that, a lot of the dollars that we put into the psychiatric care might not produce good outcome. I would urge you to look at that part of it; the housing piece is critical for us.

Senator DANFORTH. Just one more question to Mr. Cooper and Dr. Morse. It has to do with Medicaid mandates and optional services under Medicaid. I know that the States hate mandates, and I understand that. I asked Ms. Nye about the Budget Reconciliation Act of 1987, and the provision is on an optional basis for covering clinical services for the homeless mentally ill.

Do you have any knowledge of how that is working out, and do you have any view? I am not going to ask you to testify against your own State administrations, but do you have any view of the efficacy of optional provisions under Medicaid?

Senator MOYNIHAN. Perhaps Mr. Posey might have a few.

Senator DANFORTH. Yes.

Dr. MORSE. I was going to say as an official State employee, I would reflect the official position that there is concern about mandated Medicaid. As a private citizen, and one who is knowledgeable about the long history of neglect by individuals in all layers of government toward mentally ill and homeless people, I would feel very strongly that it is important to have mandated services to the mentally ill homeless least we repeat history, and these individuals go unserved in the future.

Mr. COOPER. I am not an employee of the Department of Mental Health, so I feel free to speak about my Commissioner's position. As a matter of fact, I think there was a letter addressed to the committee from the director of Mental Health of Michigan. I would totally support every item in the letter except one. And the one that the local practitioners feel they cannot support is the optional element.

Our experience with optional programs at the local level is that they do not tend to deliver the type of services we need for the customers coming to us, or that we serve through outreach activities. So, very clearly from the practitioner's perspective, an optional approach is not useful in delivery of services.

Senator DANFORTH. Thank you. Mr. Posey, do you have any comment?

STATEMENT OF TOM POSEY, PRESIDENT, NATIONAL ALLIANCE FOR THE MENTALLY ILL, ARLINGTON, VA

Mr. POSEY. Thank you, Mr. Chairman. For the record, my name is Tom Posey, and I am the president of the National Alliance for the Mentally Ill. I come to this table from the same avenue that Lionel comes. I am diagnosed as having an illness myself, and have been committable, and committed at various times.

We are approaching an extremely complicated subject, and, quite frankly, I have been somewhat disturbed by what I have heard as band-aid answers today; bigger hospitals; better staffs; better case management; better this, better that.

And all of these are necessary, but the thing that we seem to forget is that the individual down on Constitution Avenue is number one, a human being. And she needs all the elements of life that any other human being needs.

I can tell you quite frankly that it is very hard to take Lithium, or some of the other psychotropic medications, if you have got an empty stomach, because the upset stomachs. It is also very hard to reflect on whether you are the product of poor potty training or not, when you do not have a bed to sleep in, or one that you consider is safe. So we have got to begin to approach the problem from fulfilling not only the psychiatric need, which is great, but the human need, as well.

In many cases, what we have are people who have simply exercised a great American privilege, and that is their privilege of voting. They have voted to reject the services that were available, not because they might not have been appropriate to somebody's need, but simply were inappropriate to theirs.

One of the problems with deinstitutionalization was that we based the system we provided in the community on a system that had originally been designed for the developmentally disabled: the caretaker type of system. The mentally ill are a totally different population. In many cases, God has been quite kind to us in giving us above-average I.Q.s, and yet, we still suffer from an illness.

One of the most humiliating times that I ever had to go through in my treatment process was when, as a man of 43 years old with what I think was above-average intelligence—certainly enough to get me through a number of college degrees—I was expected as a course of treatment to play balloon volleyball. Balloon volleyball is when you blow up a surgical glove, and then bat it over a net. I found that humiliating, and yet, that was a treatment modality that was offered to me.

What we need are many varying treatment modalities so that people will not reject what is there, but find that which is appropriate for their needs. So we must begin to focus on the humanity of the individual, not just on the psychosis.

[The prepared statement of Mr. Posey appears in the appendix.]

Senator DANFORTH. Thank you, Mr. Chairman.

Senator MOYNIHAN. Thank you, Mr. Posey. We had not heard from you in a formal way. Perhaps I could take a statement from Dr. Morse's testimony and address it to Mr. Aldridge. You say that one homeless person in four has been robbed or beaten, of the females, one in seven has been raped. Now, that is data from where, sir?

Dr. MORSE. That is data from a random representative study in St. Louis in the mid-1980's.

Senator MOYNIHAN. That is St. Louis. Has it been replicated, or rather, are there equivalent studies?

Dr. MORSE. Unfortunately, not many studies have looked at that particular issue. There is——

Senator MOYNIHAN. You would think the National Institute of Mental Health might find some resources for it, would you not? Would you send that to the committee?

Dr. MORSE. I would be glad to.

[The information appears in the appendix.]

Senator MOYNIHAN. I mean, that is a powerful number. One in every four robbed and beaten, one in seven raped. That raises questions of civil liberties that may be the other side of the coin of why we are asking that person to come in here. Could I ask Mr. Aldridge, in your experience, was that sort of victimization something you could see?

Mr. ALDRIDGE. It is not something I saw a lot of personally. I know that it does happen, because the mentally ill are easy prey on the streets. I have seen some information on how much we are victimized, but I did not personally see that happening.

Senator MOYNIHAN. Yes. But you heard of it?

Mr. ALDRIDGE. Yes.

Senator MOYNIHAN. Well, the first responsibility of government is to the physical safety of such persons, and we do not do that even.

I want to thank you all. The committee is very much in your debt. You bring us an immediacy and a clinical capacity which is rare in our hearings on any subject. We are much in your debt. I hope you know that.

Mr. Posey, Mr. Aldridge, we are very particularly in your debt for coming to us and speaking with such clarity and candor. That, too, is rare in our sessions. Thank you gentlemen, all.

And now, a final panel of distinguished practitioners. Ms. Lee Partridge, who is chief of the Office of Health Care Financing in the District of Columbia, who will be speaking for the State Medical Directors' Association, and for the APWA, the American Public Welfare Association. Ms. Partridge.

And Dr. Richard Surles, who is the New York State commissioner of mental health, and a consultant to the Federal Task Force on Homeless and Severe Mental Illness. We welcome you both. Ms. Partridge, perhaps you would begin, as is our practice.

STATEMENT OF LEE PARTRIDGE, CHIEF, OFFICE OF HEALTH CARE FINANCING, DISTRICT OF COLUMBIA, REPRESENTING THE STATE MEDICAL DIRECTORS' ASSOCIATION OF THE AMERICAN PUBLIC WELFARE ASSOCIATION

Ms. PARTRIDGE. Thank you very much for the opportunity to testify this morning on S. 62. I am speaking from my perspective as a Medicaid director here in the District of Columbia on behalf of my 53 colleagues across the country.

There are three principal points I would like to make. One is, of course, to repeat our general request for no mandates in expanding services or eligibility requirements under Title 19, the Medicaid program.

However, Medicaid directors do welcome options, and we would support S. 62's provisions if they were optional. We would also like to make two major suggestions that are of a more technical nature.

The first has to do with your presumptive eligibility provision. Medicaid, as you know, is an insurance program. We pay claims for services rendered by eligible providers to eligible people. As you know, it is difficult to make mentally ill people eligible for Medicaid simply because of the nature of their lives. They tend not to reappear for appointments with social workers; they will come in once, but not come in twice, or three times. Therefore, even if you were to cover outreach services under the Medicaid program—and here in the District of Columbia we do—we do not have an eligible client at the other end. One possibility would be to expand your presumptive eligibility language here to cover the client from the time that the mobile outreach worker first makes contact. That is a technique we have used with respect to pregnant women, and it is a device that might work rather well here.

If you do that, however, we would also need a little bit of guidance on who would be able to make that kind of determination. I think the present language in the statute deals with neighborhood health centers, and so on. Probably we should also let the States have some options to cover, perhaps the social worker on the mobile outreach team.

Senator MOYNIHAN. Would you just help me?

Ms. PARTRIDGE. Yes.

Senator MOYNIHAN. Where is this in your testimony? I want to hear that very carefully and mark that up.

Ms. PARTRIDGE. Page 7.

Senator MOYNIHAN. Page 7. All right.

Ms. PARTRIDGE. Yes.

Senator MOYNIHAN. Now, remember, I am a slow reader. Middle paragraph there?

Ms. PARTRIDGE. Yes, where it says client eligibility.

Senator MOYNIHAN. Yes. Yes. Yes.

Ms. PARTRIDGE. It goes on to the top of page 8.

Senator MOYNIHAN. All right. Go ahead. Go right ahead.

Ms. PARTRIDGE. The second question has to do with the discussion that has come up earlier about what constitutes an institution for mental disease, and whether or not someone who is in an institution for mental disease who is between the ages of 22 and 64—and I think most of this population we are talking about today would be in that category—we would like to see the referral centers excluded from the definition of an institution for mental disease.

In other words, if the referral and assessment center is to provide room and board, that would now be looked at by me and by my colleagues, and by HCFA, as an institution for mental disease.

Some of these persons will need treatment other than that institution for mental disease would afford, such as medical treatment for wounds; or dental work; or something like that. While they are residents of an IMD, I am precluded for paying for those services from them. So, again, I think we need to clarify that we do not intend the centers be IMDs.

Senator MOYNIHAN. All right. I think we understand that, do we not?

Ms. PARTRIDGE. All right.

Senator MOYNIHAN. Do we understand that?

Senator DANFORTH. I think we intended to do both of those things, but we will look at the legislation again.

Ms. PARTRIDGE. Finally, I share some of Senator Moynihan's institutional memory. I was on the staff of the late Senator Javits from 1958 to 1965. I remember the passage of the Community Mental Health Centers Act, and I am concerned that people will think that if you expanded Title 19 to cover more services to the mentally ill, that that is enough, because it is not enough.

As we all know, the services needed are far beyond just the medical ones. The housing ones, of course, are very substantial here in the District of Columbia, and we would hope that everybody would recognize that S. 62 is a piece of the solution to the problem, but certainly not the whole answer. Thank you.

Senator MOYNIHAN. Thank you, Ms. Partridge.

[The prepared statement of Ms. Partridge appears in the appendix.]

Senator MOYNIHAN. Dr. Surles.

STATEMENT OF RICHARD C. SURLES, PH.D., COMMISSIONER OF MENTAL HEALTH AND CONSULTANT TO THE FEDERAL TASK FORCE ON HOMELESSNESS AND SEVERE MENTAL ILLNESS, ALBANY, NY

Dr. SURLES. Yes.

Senator MOYNIHAN. You who are in an honorable succession from the people who started all this trouble.

Dr. SURLES. Yes, I am afraid I am. Senator, thank you for inviting me, and I really do appreciate being here. I have prepared a rather lengthy testimony.

Senator MOYNIHAN. We will place in the record as it is read.

[The prepared statement of Dr. Surles appears in the appendix.]

Dr. SURLES. Yes. I will not bother to——

Senator MOYNIHAN. Take your time. Take your time.

Dr. SURLES. I wanted to highlight a few issues, and center on New York since that is what I know best, and to try to frame some of the issues that I think S. 62 attempts to address.

We have already heard today some estimates of the size of the problem, and I thought it might be helpful to also break down the issue of when we talk about people who are mentally ill and homeless, in many cases, it is an issue of where are those people located. And I think much of the testimony you have heard today, especially in terms of the efforts that are currently under way on behalf of persons who are mentally ill, refers primarily to persons residing in some form of shelter. That what I think S. 62 does is really to focus on the unsheltered.

For example, in New York State, we estimate—and probably this is our own administration's estimation—that at any given time 48,000 people are homeless, no matter the background.

Of that number—and this is a population that we can be most certain about—about 12,000 single adults on any given night are in some form of shelter where about 10,000 of those being in New York City. Most of that single adult population is male, tends to be in the age of 21 to 45, and among that population, there tends to be a very high incidence of substance abuse. It is a population that tends to be quite mobile, and quite aggressive.

We also estimate that at any given time, about 20,000 families, primarily women and children, are in some form of supported residential facility, be it either a hotel, or some form of structure.

Our numbers are that 16,000 on any given night—and I think there is some season variation to this—remain unsheltered. And again, our numbers suggest that 92 percent of the total homeless population are in New York City. Conservatively, we estimate that one out of four among the homeless would be mentally ill, but that the unsheltered population is substantially higher. Experience has taught me that there is also a disproportionate number of single women who are in public areas, and remain unsheltered, in part, because of their fear of the sheltered system, and the lack of alternatives for women.

The emphasis for most of the Federal outreach efforts and most of the resources that even we in New York have made available, is being spent on people in shelter. And part of that is because once someone is in the shelter, it then becomes much more possible to determine the need, and to begin the process of eligibility determination.

So when people describe the efforts underway to do outreach and bring people into the entitlement programs, for the most part, that is responding to the population in shelters. S. 62 provides a much needed focus on the unsheltered mentally ill.

It is the group that probably is most visible to all of us, and the one in which we have thus far been able to provide the least amount of concentrated services. I believe that S. 62 has identified strategies that those that have worked with the homeless mentally ill have come to accept as the most important principals. That is, street outreach; continuing engagement; access to safe, low stress reception centers. Much of the problem we face with trying to get the mentally ill into services is that they are used to two forms of services, if they are available. One, shelter usually with a large number of younger, able-bodied males, which in many cases, is an unsafe setting for them, and two, involuntary hospitalization.

We have not done very much between those two parameters, and I think S. 62 identifies the need for a new form of safe house-staging area; a place for people to go immediately from leaving the street.

S. 62 also identifies the importance of assistance in access to benefits, housing, and mental help, and medical treatment. And also—and I think that while we have heard some different testimony—I think one of the critical recognitions is that in some cases we must have the capacity to provide access to emergency hospitalization, be it involuntary, or otherwise.

We, in New York, are clearly struggling with a significant financial problem. We still have elected to make the response to persons with mental illness among the homeless a high priority. We are seeing some progress in providing assistance to those in shelters. We should do the same for the unsheltered, and, for that reason, Governor Cuomo is supporting S. 62, respecting that it may mean doing less in other areas. Thank you.

Senator MOYNIHAN. Well, we thank you, Doctor. That is what we like to hear in this committee. Let me ask the two of you, if I can. Ms. Partridge, you mentioned the age group that this area would be concentrated. Would you say that again?

Ms. PARTRIDGE. Between the ages of 22 and 64.

Senator MOYNIHAN. Yes. And that was very much the sense of 22 to half way—young to middle age.

Ms. PARTRIDGE. Yes.

Senator MOYNIHAN. What about children? I read in yesterday's Washington Post that one-third of the children in the District of Columbia are on welfare, as we call the Aid to Families of Dependent Children. Is that about the number?

Ms. PARTRIDGE. Yes, about right.

Senator MOYNIHAN. So they would also be eligible for Medicaid.

Ms. PARTRIDGE. Yes.

Senator MOYNIHAN. And I can draw on a private conversation with you, Dr. Surles, that the effect in the aftermath of some of the drug epidemics that we have either been through, or are going through, there are children who are coming along who have been either pharmacologically affected, or just the psychological experience of deprivation of various kinds. We are dealing with not just homeless adults with mental difficulties, but with children as well, are we not? Would you seriatim to respond to that?

Ms. PARTRIDGE. Yes. Oh, yes.

Senator MOYNIHAN. What do you find here in the District?

Ms. PARTRIDGE. We have a substantial number of families in our shelter program, mostly because of the problems of housing. And I think that same article you were reading in yesterday's Post talked about the average cost of housing in the District being out of reach for somebody on welfare, and our housing assistance programs help, but they just are not big enough.

Senator MOYNIHAN. Getting on welfare is, itself, has aspects of behavioral disorders.

Ms. PARTRIDGE. Yes.

Senator MOYNIHAN. What would you estimate——

Ms. PARTRIDGE. But not entirely. I mean——

Senator MOYNIHAN. Not entirely.

Ms. PARTRIDGE [continuing]. When the economy is not wonderful, even if you would like to work, you cannot necessarily find a job.

Senator MOYNIHAN. Yes, that is true. But that does not get around—I would suppose that about 80 percent of the children born this year in the District of Columbia can expect to be on welfare before they are age 18. Would you not say about that?

Ms. PARTRIDGE. Did you say about half?

Senator MOYNIHAN. About 80 percent.

Ms. PARTRIDGE. Oh, no.

Senator MOYNIHAN. Of the children turning 18 today and this year, what proportion have been on welfare?

Ms. PARTRIDGE. That I would not know. We could—I am sure we could run our computers on it and do that.

Senator MOYNIHAN. Really?

Ms. PARTRIDGE. Yes. If we look at, for example, the average length of time someone is on welfare.

Senator MOYNIHAN. Do that, would you?

Ms. PARTRIDGE. Yes.

Senator MOYNIHAN. The APWA has been very protective of this data. It is called protecting the good name of the clients. It does not help the clients one damn bit.

[The information follows:]

APWA does not collect information on the average length of client stay on welfare. APWA also does not collect information on proportion of children turning 18 years old who have been on welfare during their childhood. APWA does annually collect data on fostercare and adoption assistance through the Voluntary Cooperative Information System (VICS). This information is published annually.

Senator MOYNIHAN. We have taken the PSID data and have run it for the—which was the one thing we did in the OEO if we did nothing else—we set up the money in Michigan to keep track of 5,000 families, and the panel has now been expanded. It is called the "Panel Study of Income Dynamics." And of children born in 1967 to 1969, 22 percent were on welfare by age 18. And for minorities, it was 72 percent. And we find that we cannot get higher than that, but if we just go zero to seven, we see a very sharp increase from the sixties to the early eighties, and then it seems to steady off.

But that would give us about a third of all children nationwide, 32. something percent. And among minorities, it was improbable but statistical projection of 82 percent. So why do you not look at—find out about it. Tell us something we do not know. Unless, Dr. Surles, you think children——

Dr. SURLES. Well, I think clearly among the homeless in the—I mentioned earlier in terms of the 20,000 people in New York and families, we are seeing—especially in New York City—high incidence of the mothers being addicted especially to cocaine, and that we are seeing for children now, 4 and 5 years old that are beginning to come into the school system, the consequences of the addiction of the mother on the child.

We have also in the last 5 years experienced a dramatic change in the admissions pattern of young children to State psychiatric hospitals. We operate 600 beds in 11 different sites, and we are now seeing very young children—3, 4, and 5 years old—come into those psychiatric hospitals, whereas in the past, that would have been extraordinarily rare. And those children, many of them, in fact—probably 75 to 80 percent—are from families that have been identified as part of the Protective Services Program, and many of them, especially in the city, are suffering psychiatric symptoms that we believe come from a combination of the consequences of the addiction of the mother, plus the family situation.

Senator MOYNIHAN. I think that is something new. I heard Dr. Surles say, Senator, that it used to be extraordinarily rare to see a very young child in a psychiatric situation. It is not now.

Dr. **Surles**. No. It is another way of thinking about creating the next generation of very dependent people that will be a responsibility of government. If the children are so damaged that they will be in some form of governmental care for the rest of their lives, that has not only huge social consequences, but it has tremendous economic implication, and is a phenomenon that probably is not receiving the attention that it should.

Ms. **Partridge**. Senator, I might add that here in the District, in cooperation with one of Dr. Surles' former colleagues, Dr. Johanna Ferman, who was the Deputy Commissioner of Mental Health in New York, the Medicaid program and the institute of which she is now a medical director is starting a major program to help the children of substance abusing women with early intervention programs in the hope that they would never see the inside of an institution, and that they would be able to function when they reach school.

Senator **Moynihan**. In the hope.

Ms. **Partridge**. In the hope.

Senator **Moynihan**. Senator Danforth, would you conclude our very stimulating morning?

Senator **Danforth**. Mr. Chairman, thank you. Ms. Partridge, just a few questions for you.

Ms. **Partridge**. Yes.

Senator **Danforth**. And let me admit in asking the questions that I do not pretend to be an expert at all about the intricacies of Medicaid law, and you are. You have been working with it for quite a time.

Ms. **Partridge**. Well, we work at it, Senator.

Senator **Danforth**. But let me tell you what we meant to do, as I understood it.

Ms. **Partridge**. All right.

Senator **Danforth**. And then you tell me if this is what you need to do.

Ms. **Partridge**. All right.

Senator **Danforth**. And if we agree on it, then maybe we can get together and figure out how to accomplish it.

Ms. **Partridge**. Fine.

Senator **Danforth**. The first thing that we meant to do is to say that with respect to these people, whatever the program is we have here, mentally ill people are not likely to be carrying around financial records.

Ms. **Partridge**. Right.

Senator **Danforth**. It is going to be very difficult to be absolutely sure whether a person who is on a bench is actually eligible for Medicaid, or not. Very likely they are. Maybe they are not. Maybe Lionel Aldridge had sufficient resources that he was not, but for the purpose of the outreach program and for the purpose of the diagnostic component, we have to just assume that they are Medicaid eligible without punishing the State for including the person under Medicaid if there is a mistake. So there is just a presumption. That is what we intended to do. You agree with that, do you not? I mean, that that should be the goal.

Ms. **Partridge**. Yes.

Senator DANFORTH. Whether we accomplished it in the legislation, we will look at. You do not think we did?

Ms. PARTRIDGE. No. As I read it, I do not think you did.

Senator DANFORTH. All right. Well, could you——

Ms. PARTRIDGE. We would be glad to work with you.

Senator DANFORTH. Would you, please?

Ms. PARTRIDGE. Yes.

Senator DANFORTH. And just share your problems.

Ms. PARTRIDGE. Absolutely.

Senator DANFORTH. Because that clearly is——

Ms. PARTRIDGE. Absolutely.

Senator DANFORTH. And when I visited with our people in our State, that was one thing that they made very clear they wanted to accomplish.

Ms. PARTRIDGE. Oh, yes.

Senator DANFORTH. Good.

Senator MOYNIHAN. Dr. Surles, would you be of the same view on this matter?

Dr. SURLES. Yes. We have had some experience with street outreach in New York with some of the orientation that the legislation recommended, a project called Project Help that last year made about 11,000 contacts with people on the street, and did select to transport over 700 people for emergency evaluation and voluntary treatment. And in 92 percent of the cases, the medical emergency room did find that they had made the correct street assessment.

So I think the goal you wish to achieve is achievable. It does become to the issue of the composition of the team, and the protocol around what is the State law for commitment, and what is the alternative that we seek to take people. I think it is very doable.

Senator DANFORTH. What I am talking about is eligibility. I mean, whether these people are eligible under Medicaid by way of their financial state.

Dr. SURLES. Our experience in the shelters—and we do use presumptive eligibility, and you are going to find cases in which someone has assets that we were unaware.

Senator DANFORTH. Right.

Dr. SURLES. But for the most part, that is the great exception.

Senator DANFORTH. We have been trying to give you the cover, but Ms. Partridge does not think we did it in the legislation. So if you could——

Ms. PARTRIDGE. We would be glad to.

Senator DANFORTH [continuing]. Coach us on that, we would sure appreciate it.

Ms. PARTRIDGE. Sure.

[The information follows:]

APWA RECOMMENDS THAT S. 62 BE MODIFIED IN THE FOLLOWING WAYS

(1) that S. 62 services be made optional Medicaid services

(2) that states be allowed to target services to certain urban areas within a state

(3) modify the current Title XIX payment exclusion for residents of an IMD to permit payment for S. 62 services

(4) begin the S. 62 presumptive eligibility period at the time a client is brought to an assessment-referral center

(5) clarify that presumptive eligibility is a state option under S. 62

(6) amend Title XIX to specify who may be a provider qualified to make presumptive eligibility determinations since current statute requirements are not completely appropriate for the purposes of S. 62.

Senator DANFORTH. The second is with respect to the institutionalization, and the fact that under current law, a mentally ill person cannot receive Medicare for being institutionalized if that person is between the ages of 21 and 65. Now——

Ms. PARTRIDGE. That is essentially how HCFA reads it, yes.

Senator DANFORTH. All right. Let me tell you——

Ms. PARTRIDGE. That what the language says is we may not pay for persons in institutions for mental disease between those ages—they are not eligible.

Senator DANFORTH. All right. Let me tell you what we intended to do, and then ask you if you would again help us with this one.

Ms. PARTRIDGE. Yes.

Senator DANFORTH. We want the person taken someplace, consistent with State law.

Ms. PARTRIDGE. Right.

Senator DANFORTH. Now, the State law on voluntary commitment might be rather broad, or it might be just if this person is a danger to himself or somebody else. Whatever it is, consistent with State law, we want to try to either bring or somehow induce the person to go to a place——

Ms. PARTRIDGE. Right.

Senator DANFORTH [continuing]. Where that person will receive diagnosis and be put on some sort of treatment program.

Ms. PARTRIDGE. Yes.

Senator DANFORTH. We do not want to determine what that place is.

Ms. PARTRIDGE. Right.

Senator DANFORTH. We want the states to be able to do that. And it was our view that the language that we have here would supersede the existing restriction, but again, you agree with our objective. In other words, if a State says, look, this person really should be in a hospital setting, in an institutional setting, that is how we prefer to do it, or if it should be in a clinical setting, whatever, the flexibility should be there. Do you agree with our objective?

Ms. PARTRIDGE. We agree with your objective. Not everybody would even need to be in——

Senator DANFORTH. Yes.

Ms. PARTRIDGE [continuing]. The residential assessment centers. Some of those——

Senator DANFORTH. But it should be open to you.

Ms. PARTRIDGE. But your decision to include the room and board component as something that I could pay for as the Medicaid Director facilitates a center which is also a partially residential program.

I think what we would suggest is an amendment—on the top of page 7 of the bill—to number two, which would make it clear that we could fund that service, that center, if it were determined to be an IMD, and the people do not lose their Medicaid eligibility because they are there.

Senator DANFORTH. Yes. I think that in both cases our objectives are the same.

Ms. PARTRIDGE. Fine.

Senator DANFORTH. Or at least the goals are the same.

Ms. PARTRIDGE. Yes.

Senator DANFORTH. I do not—again, and I never will know enough about the Medicaid law to know how to do it, but that is the objective. So if we could get in touch with you and work those out.

Ms. PARTRIDGE. We will be pleased to. There is a long history of disallowances of Federal reimbursement——

Senator DANFORTH. Yes.

Ms. PARTRIDGE [continuing]. To institutions for mental disease, and we do not want to——

Senator DANFORTH. I know. We want to loosen that.

Ms. PARTRIDGE. And we do not want to get into that problem.

Senator DANFORTH. Our objective is to give you additional flexibility.

Ms. PARTRIDGE. Thank you.

Senator DANFORTH. Now, one final question. Let us say that we passed the law with these two points accomplishing what we intend, and what you would like. And but further ascend that instead of being a Medicaid mandate, which it is here, it were simply an option that were made available to you, and you run the program in the District of Columbia.

Ms. PARTRIDGE. Yes.

Senator DANFORTH. And the people I pass every day on the way to work are all in the District of Columbia.

Ms. PARTRIDGE. Yes.

Senator DANFORTH. How would the law as you envision it, optional rather than mandatory, be utilized? How would it change what I actually see?

Ms. PARTRIDGE. I do not know how it would change what you actually see, because I do not know how many of those people would be willing to come into treatment. It would certainly—because we would have additional Federal funding—enhance our local capacity to put mobile outreach teams on the street.

Dr. Robert Washington, who is our Commissioner of Mental Health, believes in those teams. They are very effective. We have them in operation, but we do not have many. And this would clearly allow us to——

Senator MOYNIHAN. Clearly do not have enough.

Ms. PARTRIDGE. Right.

Senator DANFORTH. If it were mandatory, you would have to use it.

Ms. PARTRIDGE. If it were optional would we use it? Yes.

Senator DANFORTH. From the standpoint of D.C., would it make any practical difference if it were optional or mandatory?

Ms. PARTRIDGE. Oh, yes.

Senator DANFORTH. In other words, it would be more onerous if it were mandatory?

Ms. PARTRIDGE. Yes.

Senator DANFORTH. Therefore, you would use it more so if it were mandatory than if it were optional?

Ms. **Partridge**. We would use it more so. I would hope we would not be in the situation in which it were a mandatory service and we did not have the services developed to refer people to.

If it were an optional service, we would obviously phase it in over a year, or year and a half, 2 years. I do not like to be in the business of reaching people and signing them up for something, and then you cannot deliver the services at the other end.

Senator **Moynihan**. Well, a 2-year mandatory?

Senator **Danforth**. In your opinion, I guess it will be possible for us to write it in a phased in way, but I think that the concern is that if it were optional, it simply would not be used. I mean, this is what Dr. Morse said in his view. If it were optional, this is just not something that commands the kind of——

Ms. **Partridge**. Well, I think——

Senator **Danforth** [continuing]. Political——

Ms. **Partridge**. I think the response of the states to the options for pregnant women suggests otherwise. Some of our——

Senator **Danforth**. I think pregnant women are different from street people.

Ms. **Partridge**. Well, State legislatures are perhaps a little more willing to come up with the State funds, but certainly, State after State has taken advantage of those as they have some along.

Senator **Danforth**. All right. Thank you very much.

Ms. **Partridge**. All right.

Senator **Danforth**. Thank you, Mr. Chairman.

Senator **Moynihan**. We thank you. We thank all of our witnesses. It has been an extraordinarily helpful morning. We have learned from you, and we are going to pursue this matter. I think there will be no question about the judgment of our witnesses. We thank our guests and say a very good morning to you, and a pleasant weekend.

[Whereupon, the hearing was concluded at 12:05 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SAUL COOPER

Thank you very much for the opportunity to testify regarding this extremely important piece of legislation. It clearly addresses a major unmet need in mental health services and would significantly address at least some of the complex problems we, as practitioners, face.

Before comment on various aspects of the bill, let me briefly introduce myself. My name is Saul Cooper and I am a psychologist. My career in mental health began forty years ago as an attendant in a state hospital. During my first day on the job was handed a baseball bat by my supervisor and I was naive enough to believe that the ward I was assigned to had a recreational program. Since that time I have become much less naive and much more experienced with regard to the problems of persons that are homeless and mentally ill.

I have served in a variety of capacities in mental health centers both in Massachusetts and Michigan and was, for over 15 years, the Director of the Community Mental Health in Washtenaw County. Presently, I am Director of Human Services for this county and I am actively involved in integrating several different human service programs so that we can truly deliver "one stop shopping" not only for homeless persons with mental illness, but also for other consumers of services.

In addition, I am presently adjunct professor of psychiatry at the University of Michigan Medical School and an adjunct professor of psychology in the graduate school. I have spent my entire professional career in working directly for community mental health programs and my community mental health program has been a long time member of the National Council of Community Mental Health Centers. Once again I thank you for the opportunity to speak on the basis of real field experience.

Community mental health programs today are far from adequate in meeting the needs of many of their clients and, especially, persons that are homeless and mentally ill. Our center, like most, has had to eliminate services for the less severely ill, consultation services and prevention programs. The population we serve are essentially without resources, have a multiplicity of economic, physical and psychological needs and our center has extremely limited resources to respond. Much has been said about why community mental health programs have failed to meet their promise of 1963. It is my impression that many state and local program were not supported by either the local citizenry or the political process in seriously addressing the most chronically impaired population. I believe that in most states there is a continuing and increased commitment to this population and that the passage of P.L. 99-660 (Comprehensive State Mental Health Planning Act) further enhanced this focus. The majority of community mental health programs in the country are, in my opinion, committed and prepared to respond to persons that are homeless and mentally ill but the lack of resources is of major consequence.

Much has been written in the media about this population. We hear that all the homeless are mentally ill; that they are all perfectly content to live on the street; that they are all substance abusers; and that most of them are capable of self-sufficiency if only they had the strength of will. As I am sure the Committee members know, none of these perceptions fit reality. We have learned a good deal from the NIMH-McKinney service Demonstration Projects and we believe that we do know how to serve this population. What we need is money, not demonstration projects and I believe that S. 62 would provide a significant step in the right direction.

My state is now operating the Michigan McKinney Service Demonstration for Genesee and Washtenaw Counties. Staff at both project sites have successfully provided a range of intensive support services and housing assistance to homeless mentally ill adults that include the following: outreach to the shelters and streets, psychiatric hospitals, and community settings; intensive case management; assistance in selecting, finding, and keeping permanent housing; innovative payee services; linkage to mainstream support services; and consumer run self-help activities. Of the 242 individuals approached by the program in a 14 month period ending in December 31, 1990, 82 percent (199) voluntarily agreed to accept some assistance. The Washtenaw site has succeeded in securing permanent housing by accessing a limited supply of Section 8 vouchers. The Genesee site has addressed its need for transitional housing by implementing a 6-bed transitional boarding home. As of September 1, 1990, 82 percent of completed follow-up interviews found project clients living in permanent settings.

If I may, I would like to comment on sections of the bill in order:

STATEMENT OF PURPOSE AND FINDINGS, SECTION 2

The fact that this bill recognizes outreach as a critical element to approaching this population is very positive. The emphasis is on identification of these individuals, consistent with local efforts begun in the mid-80's that have been funded erratically at the county, state and federal levels. This population is diverse with a variety of clinical presentations and personal stories. The bill's emphasis on an individual treatment plan recognizes that people do not end up among the homeless for the same reasons and, therefore; the approach to addressing their problems must be based on the complexity and status of each individual.

Our demonstration projects in Michigan for persons who are homeless and mentally ill have shown us that community mental health programs could serve many more chronically mentally ill persons if they had resources for more supported, independent housing, more intensive case management, and more daytime psychosocial rehabilitation services. Such resources would enable community mental health programs to offer clients meaningful choices about living arrangements and support services.

The statement of purpose under Section 2.b.7 would be most welcome, if what is meant is that the National Commission will take local experience from across the country, in the variety of contexts in which different systems operate, and then report to Congress that which seems to work best. Taking what is learned in the field, as well as implementing selected recommendations coming from NIMH studies, and developing this into national policy, via the federal State Mental Health Planning Act, the new Projects to Aid the Transition from Homelessness, (PATH) and Medicaid coverage policy is a desirable approach to planning. This assumes that the emphasis of national policy-making will include an emphasis on local experience as one major basis for national policy, with the necessary concomitant flexibility to implement national policy within the existing local system.

In terms of our experience in Washtenaw County we have been providing outreach to the this population in excess of five years, primarily at all of our shelters, and in so doing have learned a great deal. The first step that outreach represents, as we have learned, is one of engagement; building trust by meeting the client on his or her own terms. If this step is missed, a "treatment plan" will not stick. We are still learning, and have much to do to improve how we serve these people, but building on what we and others have done and learned would be more efficient and cost-effective than starting over with a significantly new service model.

COVERAGE BY STATES OF MOBILE OUTREACH UNITS SECTION 3 a.7

There is no predictable relationship between Metropolitan Statistical Areas and the geographic organization of local mental health services. In some states the MSA happily coincide with county and CMH catchment area boundaries. In others, MSA's may be incompatible with these boundaries. An effort to create new service areas based on MSAs, could produce a level of disorganization and conflict not seen since the War on Poverty, aptly described by Senator Moynihan more than 20 years ago in *Maximum Feasible Misunderstanding*. The use of existing State Mental Health Authority frameworks (or catchments) would be much more appropriate.

SECTION 3 (A) (i)

A great deal has been learned about screening for mental illness and homelessness. One relevant publication on this topic comes from researchers in New York City, Susser & Struening, *Homelessness in Mental Patients: Lifetime Prevalence and*

Childhood Antecedents 1990. This is far more complex than simply picking up people on the street whose appearance or behavior is disturbing. Reliable screening requires training, tested protocols, and good working relationships with shelter providers and others who can share key observations. Michigan has been doing this in shelters in both Washtenaw and Genesee counties for the last two years.

SECTION 3(A)(ii) AND 3(B)(i).

While "involuntary transport" might be useful under very limited circumstances, unless a person appears to meet commitment criteria, we do not, and cannot, transport on an involuntary basis. The bill would not supersede state commitment laws, so it's not clear how this would work.

- Transport and acute psychiatric care should be reserved for people having acute psychiatric crises; many homeless persons with mental illness, while in dire need, do not present acute symptoms; this approach would overload and immobilize precious psychiatric emergency resources;
- This approach is incompatible with the type of outreach that we have found to work, i.e., that brings the point of contact to the client and seeks to build trust;
- This approach will quickly teach homeless person and shelter providers not to trust or talk to the outreach teams, thereby undermining their outreach effectiveness.

MEDICAL TREATMENT AND TEMPORARY ROOM AND BOARD, SECTION 3 (B) (i–vii) (i–iii)

Currently, our county-based CMHC has psychiatric emergency services housed in our medical center; it currently works at full capacity screening for inpatient admissions and providing urgent care for acute cases. Local community mental health programs do not have resources of their own for new transitional housing for non-acute, homeless mentally ill persons; this is a real need and an area of federal responsibility; the greater need is for affordable permanent housing.

ACCESS TO SAFE AFFORDABLE HOUSING, SECTION 3 (b) 61 B (1–5)

We have great difficulty finding affordable rental units. The average SSI recipient in our system receives approximately $420/month in income. The average room in Ann Arbor/Ypsilanti, is $250/month, which consumes about 60% of monthly income. What would make an enormous difference would be greater availability of and easier access to "dedicated" Section 8 vouchers. We applied for some 70 vouchers through the Plymouth HUD office last year (for our Homeless Project and community mental health clients) and as some few are approved the difference in quality of housing people can attain is remarkable. This improved standard of living, in turn, improves stability of mental status, in that the Section 8 voucher is an additional resource a very poor person can use, their housing is more normalizing, e.g., an apartment rather than a room with bath shared by strangers and no cooking facilities.

Safe permanent, affordable housing with flexible supports is the over-arching need in most communities. It is extremely difficult to find and even harder to hold onto. This is a major area of frustration for outreach workers. A development effort at the community state and federal levels is required. The withdrawal of federal housing support over the last decade was a major contributing factor to the homelessness we now confront (*Life In Transit,* Michigan DMH). There are local initiatives at housing development, painstaking "points of light," often supported by private sector groups on shoestring budgets. As long as these "points of light" are surrounded by federal darkness, they will burn themselves out in the futile effort to keep pace with an expanding homeless population (Cohen, Mowbray, Gillett, & Thompson, "Religious Organizations and Housing Development" *Prevention in Human Services.* In press).

In addition, the bill assumes 90 days would be sufficient to identify, evaluate and develop a (meaningful) treatment plan. In many cases it's not likely to happen and be a plan that "sticks" over the longer haul because of the lack of available treatment resources. Medicaid coverage for the comprehensive treatment and support services necessary for this population is severely lacking throughout this country. Furthermore, reimbursement through Medicaid is often tied to an MD's signature on a treatment plan. However, before a homeless person ever sees a psychiatrist, there is a lot of service "overhead" that goes into working with them. That overhead, i.e., all the outreach and evaluation, is not a covered expense for too many programs.

NATIONAL COMMISSION, SECTION 4

I applaud the establishment of a National Commission for the Homeless Mentally Ill, its Mission and functions.

All of us professionals look forward to success in your efforts as represented by Senate Bill 62 and we thank you.

PREPARED STATEMENT OF GARY MORSE

My name is Dr. Gary Morse. I have worked in the area of homelessness since 1980. I work currently as the Director of the Community Support Systems in St. Louis, an organization whose mission is to provide needed services—such as outreach and case management—to homeless mentally ill persons and to conduct research on the needs and solutions involved in homelessness. I am honored and pleased to speak today before you as members of the U.S. Senate, and to be participate in the hearing with Dr. Oliver Sachs, who affirmed for America in the movie *Awakenings* the possibility of a better and richer life for those people who suffer from severe disabilities.

Thinking of Leonard Lowe from *Awakenings* played by Robert DeNiro, reminds me of another American, Mr. C., who also suffers from a long-term disorder. Mr. C.'s story is different than Leonard's in significant ways, of course. Rather than suffering from post-encephalitis, Mr. C. has a major mental illness, schizophrenia, although to many individuals and their families, it also is traumatic and mysterious. Though he has been hospitalized on scores of occasions for brief periods of time, Mr. C. spent approximately eight years of the last decade not in institutions, but in America's "emergency shelters" for the homeless and on the streets.

Mr. C. is a black man in his late thirties from Middle America. But two images will provide a better introduction than demographic information.

The first time I met Mr. C., in the winter of 1988, his long body was sprawled across a tattered love seat at a daytime shelter for homeless mentally ill people; his arms stuck out to the side, contorted and slightly flapping against his sides. As I introduced myself, he climbed to his feet and I could see that mucus and food crumbs were smeared across the stubble of his beard. He inadvertently spewed considerable spit, some of which landed on my face, as he spoke, panhandling me for bus fare and money for food and cigarettes.

The first half of the second image begins 18 months later at a barbecue and softball game for the homeless clients we work with to celebrate Memorial Day. Mr. C. arrived at the BBQ with his outreach case manager, dressed in clean white slacks, a sports shirt, and a red-white-and- blue fisherman's cap with "1984 Olympics Los Angeles" on it. Mr. C. was grinning and talkative during the picnic, but, in stark contrast, grew quiet, even serious during the softball game. As I watched him crouching at first base, intently staring at the batter, I thought that the transformation from the first time I saw him 18 months prior was almost surreal. It reminded me of another popular movie I saw during that time, *Field of Dreams*. That movie involves a young Shoeless Joe Jackson appearing in the 1980s on a ball field that an Iowa farmer carves out of his corn field. More than that, it was a wonderful movie about being able to play out unfulfilled dreams on the baseball field.

But for now, as much as I enjoy baseball, I will veer away from the national past time to one of America's most pressing domestic problems. Mr. C. is one of approximately 1 million Americans who are homeless each year. Most research suggests that somewhere between 25% and 40% of these homeless individuals—250,000 to 400,000 people annually—suffer, like Mr. C., from a major mental illness.

Mr. C. and the others suffer not only from mental illness—a generic term that covers a number of disturbing and often disabling psychiatric disorders—but from a number of other pressing problems and needs, including: [1]

- Permanent Housing
- Employment
- Job training and vocational rehabilitation
- Financial assistance: the average monthly income being less than $25 in one study
- Social support—homeless mentally ill people have far fewer friends or family providing them with emotional or material support than the general population or even other homeless people

Some of the homeless also have additional, specialized needs:

- Approximately one-third of homeless mentally ill people have a second or dual disorder of substance abuse
- About one-fourth of the homeless have been beaten or robbed while on the streets and approximately 1 in 7 women have been raped or sexually abused; the mentally ill are the most likely of the homeless to be abused

What is disturbing is not only the high level of these problems and needs, but also the lack of help which is being offered to these Americans. For example:

- Only one in five was being assisted to find permanent housing or employment, respectively
- Only about 15% of the homeless were currently receiving mental health services

The lack of assistance is even more disturbing given the willingness of most homeless people to improve their lot. Nearly all homeless people are interested in receiving help to find permanent housing. Similarly, nearly all want help for finding a job—far more than who are interested in receiving financial assistance—reflecting, I believe, deep-seated American values about working and self-sufficiency.

Contrary to stereotypes, the majority (83.7%) of homeless people with severe mental illness are also interested in receiving some form of mental health services. However, there is a mismatch between the types of services that homeless mentally ill individuals desire and those that the system typically provides. Inpatient hospitalization and psychiatric medication are typically provided and, while these may be often needed, they tend to be of the least interest to homeless clients who more strongly desire assistance for housing, case management, and outreach.

It is essential that services like outreach and case management are provided. Outreach is important because it is a means for:

(1) contacting homeless mentally ill people who are likely to be out-of-touch from needed services
(2) beginning to established trust and communicate caring to those who have become isolated and neglected
(3) instilling hope in those whose lives have become full of despair and frustration
(4) providing immediate assistance (e.g., food, clothing) as needed
(5) linking individuals with needed follow-up services and resources

Case management, meanwhile, is needed as follow-up in order to:

(1) continue a caring, therapeutic relationship, and help people to learn to better cope with their illness and the world
(2) help clients to obtain needed services and resources—like medication and Section 8 housing certificates—from a maze of bureaucratic systems that are often unresponsive
(3) provide the on-going environmental supports needed to help disabled people manage their needs, including, for example, managing medication, money, and other unglamorous, but needed activities, like helping people clean apartments.

The services of outreach and case management—in stark contrast to the myth that "the homeless can't be helped"—are effective ways to help. The first scientific, experimental study of programs for homeless mentally ill people living on streets and shelters[2] found that homeless mentally ill people, when outreached and linked for service to either (a) an outreach/intensive case management program or (b) an outreach/day program, or (c) a community mental health center outpatient clinic, improved over one year's time in a number of areas, including:

- decreasing time homeless/increasing time housed
- increasing their income
- decreasing psychiatric symptoms
- improving interpersonal adjustment
- increasing self-esteem

The study also found that the outreach/intensive case management service (the Community Advocacy and Support Alliance or CASA program) was the most effective service approach for:

- creating social stability and maintaining treatment contact with a population that can be elusive
- getting clients linked with other needed services and resources
- producing positive consumer satisfaction, and most importantly,
- reducing homelessness and increasing stable housing.

The differences on these two variables were vast: while 100% of the clients were homeless when they were referred for outreach/case management service, 85.5% were housed for the entire month at the time of their 12-month follow-up assessment. (An alternate statistical presentation is that prior to treatment the average number of days homeless per month was 26 days but after one year it had been reduced to less than 3 days).

These positive results should not be considered limited to a single research program. From other programs we operate in St. Louis and consultations with a number of other programs across the country, it is clear that homeless mentally ill persons do improve when provided with sensitive and caring service and appropriate resources. While to some extent we are still learning as we go, developing and refining our techniques with what can be a challenging population to serve, it is clear that our existing technology is adequate to make a difference.

The differences that we make may be less dramatic than the stunning reversal for Leonard and the other patients depicted in *Awakenings* and yet it is significant that we can reduce homelessness from 100% to 14% of the CASA clients within one year. Further, the improvement in the quality of human life can also be marked, even if it is perhaps too subtle to scientifically measure.

I think again of Mr. C. Mr. C. is not our most successful client. Willy, for example, has changed from an isolated, chronic street person, psychotic and unable to coherently communicate, to a person who is psychiatrically stable, and housed for 2½ years, including now in his own apartment, while holding down a half-time job. Or Beth, who after 26 years in the hospital and shelters and streets, is now much more stable and has been living in an apartment for almost two years. Indeed, Mr. C. is one of our most challenging clients who needs extensive support to clean and maintain his apartment, and frequent monitoring and guidance.

Still, Mr. C.'s problems and needs should be placed in a proper perspective. I think of him standing at first base, with his red-white-and-blue '84 LA Olympics cap on. You know, Mr. C. talked about being a good ball player when he was young, but, like Shoeless Joe Jackson, his career was cut short, although for a very different reason, that of major mental illness. Still, he was able to play softball that day.

During the middle of the game, there was a pop up near me. I lost the ball momentarily in the sun, and as I was circling around, I heard a thundering of feet from behind, and "I got it" yelled out.

I know that despite improvements, Mr. C. still has unmet needs—e.g., for a job, higher quality housing, and improved hygiene skills. I know there still are and will probably continue to be times of frustration and problems ahead. But at that moment in the game, those issues were lost, like the softball in the sun.

When the ball came down out of the sun, there was a moment that is hard to describe, but it was special, almost magical, by the perception of other clients and staff as well as myself. As the ball came down, Mr. C. streaked across the field, his arms and hands which are so often contorted by tardive dyskenesia, outstretched and catching the ball, playing the game in his own field of dreams, with all the grace of a Shoeless Joe Jackson.

The opportunity to live such dreams is still far from a reality for the vast majority of mentally ill homeless clients in America. It is clear that the level of services provided to the mentally ill homeless population still falls far short of the level of need.[3] Some have even called this mismatch between need and resources "a scandal of disproportion." [4]

For that reason, among others, I heartily endorse S. B. 62. I know the bill has been criticized on several grounds, including concerns about civil liberty issues, Medicaid financing, and an absence of more comprehensive measures.

While more comprehensive approaches would also be welcomed, this legislation as it stands *is* one significant and worthy step toward coming to terms with homelessness—a destructive phenomena that should be an unacceptable scene within the American landscape. And rather than turn our eyes from those who live in our streets and shelters, a situation *Time* magazine describes as "shameful indifference," [5] rather than to become lost in political battles over whose fiscal responsibility the homeless are, it is essential that we see that the problem exists, and that they are *our* homeless. In so doing, we need to reach out to *America's* homeless to engage those who have perhaps lost the ability to hope and dream and to provide them with opportunities to affirm and to live an improved and happier life, an opportunity perhaps to step onto a field of dreams. Thank you.

ENDNOTES

1. For details on these and the following needs assessment data, see Morse, G. A. & Calsyn, R. (1986). "Mentally disturbed homeless people in St. Louis: Needy, will-

ing, but underserved." *International Journal of Mental Health* 14(4): 74-94; and Tessler, R.C. and Dennis, D.L. (1989). *A synthesis of NIMH-funded research concerning persons who are homeless and mentally ill.* Rockville, MD: National Institute of Mental Health.

2. See Morse, G.A., Calsyn, R.J., Allen, G., Tempelhoff, B., Smith, R. (1991). Helping homeless mentally ill people: Experimental evidence. Article to be released for publication in May 1991; and Lipton, F., Nutt, S. and Sabatini, A. (1988). "Housing the homeless mentally ill: A longitudinal study of a treatment approach." *Hospital and Community Psychiatry* 39(1): 40-45.

3. See Dennis, D.L., Buckner, J.C., Lipton, F.R., & Levine, I.S. A decade of research and services for homeless mentally ill people: Where do we stand? *American Psychologist*, in press.

4. Hopper, K., Mauch, D. and Morse, G. (1989). *The 1986-1987 NIMH-funded CSP demonstration projects to serve homeless mentally ill persons: A preliminary assessment.* Rockville, MD: National Institute of Mental Health.

5. Toufexis, A. (October 22, 1990). From the asylum to anarchy. *Time*, 58-59.

Attachment.

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MENTALLY DISTURBED HOMELESS PEOPLE IN ST. LOUIS: NEEDY, WILLING, BUT UNDERSERVED

GARY MORSE AND ROBERT J. CALSYN

Recent research, first in Great Britain [1-6], and then in the United States [7,8], has indicated that mental health problems are common among the increasing numbers of homeless people. Relatively few studies [2-12], however, have empirically investigated the mental health characteristics and needs of homeless people. These few studies have made important contributions to documenting the existence of serious mental health problems among the homeless; but the existing literature is plagued by a number of problems, including controversial results on the rate of mental illness and limited generalizability.

Rates of mental illness across samples of the homeless range from % to 90% [10,13],[1] 50%-70% being the typical finding. The wide range of reported rates of mental illness represents not only regional differences but also varying diagnostic criteria. For example, studies that have considered persons with diagnoses of primary substance abuse or personality disorders as mentally ill have reported the highest rates [9,10]; much lower rates have been reported by investigators who exclude personality disorders and alcoholism [6].

Other important methodological shortcomings also contribute to the diversity of the findings, among them: (*a*) nonrandom samples of convenience, (*b*) small numbers of subjects, (*c*) samples selected from single shelter or agency, and (*d*) lack of quantitative assessment. achrach [13] and Bassuk [10] have recently suggested that the most significant factor behind the diversity of findings and their limited

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generalizability is the lack of random, representative samples.

In addition to the methodological problems, prior studies have overlooked matters of substantive importance. Typically, the research focus has been on psychiatric diagnoses or the presence or absence of mental hospitalization. More detailed treatment-history information, including the level a. d types of mental health services currently available, has been largely neglected.

Another important assessment area concerns *willingness to accept service*, i.e., the expressed desire of homeless people to receive human services. Professional opinion often holds that homeless people are unwilling to receive human services [14–16]. Advocates [15] for the homeless have forcefully argued a contrasting view: that homeless people are indeed interested in services, and at a greater rate than what is provided by the existing level of services. Unfortunately, there have been few attempts to assess directly the willingness of homeless people to accept services.

This paper presents selected results from a larger study of homelessness in the St. Louis, Missouri, area.[2] We shall describe the human service needs of homeless people, with special emphasis on those in need of mental health treatment. Information will also be provided on additional characteristics (e.g., demographic, social support, homelessness history) of homeless people. These findings are based on a random, representative sample of homeless people, using a data-collection instrument that includes an objective measure of mental health functioning.

Method

Participants and sampling strategy

A total of 248 persons (122 females and 126 males) who were receiving temporary housing in St. Louis area adult emergency shelters were interviewed for this study. The mean age of the participants was 30.60 years (S.D. = 9.60); nearly two-thirds (64.9%) of the sample were from racial minorities (all but 2, black); the mean education level was 11.20 years (S.D. = 2.14). Participation was voluntary, and participants were paid $5 for their interview.

Thirteen of the 16 emergency shelters in the St. Louis area agreed to participate in the study. Based on estimates from a previous study of St. Louis shelters [7], the participating shelters served 96% of the homeless men and 79% of the homeless women in the area. Sampling for each gender group was stratified by each shelter depending on the average monthly census of a given shelter. Participants in each shelter were randomly selected, by means of a random numbers table, from the current shelter census, with the one constraint that persons previously interviewed were eliminated from consideration.

The interviewer approached the randomly selected person and briefly explained the purpose of the study. During this time the interviewer also made a covert assessment of the person's competency. Five persons were judged incompetent and were eliminated from the study; ten others declined to be interviewed.

Procedure

Six males and six females served as interviewers. Most of the interviewers had had previous experience in research or clinical interviewing, but nonetheless received 15 hours of training for this project. The first author (G.M) reviewed all completed interviews several times each week to monitor sampling procedures, to check for unmarked responses, etc. In addition to conducting regular supervision sessions, he also circulated among the shelters on an unannounced basis to monitor data collection.

Participants were interviewed by a same-sex interviewer in a part of the shelter that afforded maximum privacy. Questions were read to the participant, and responses were recorded by the interviewer. Likert ratings and other more complicated response categories were displayed visually as well.

At the completion of the interview, participants who met the screening criteria for mental health treatment were referred for mental health services. Criteria for referral were: (1) prior mental hospitalization, or (2) scoring above 0.72 on the Global Severity Index of the Brief Symptom Inventory—such a score indicates that the respondent is reporting more mental/emotional symptoms than about 90% of the general population.[3]

Measures

In addition to the usual demographic characteristics of age, sex, race, education, marital status, and occupation, data were collected on the history of homelessness, including the number of times homeless, the length of time since first homeless, and the number of months currently homeless.

The negative life events and physical illness scales of Moos and colleagues [18] were also administered. Past psychiatric history and involvement in current psychiatric treatment were recorded. Psychopathology was assessed according to the Brief Symptom Inventory (BSI).[4] The BSI is the short form of the SCL-90, which was considered the best self-report symptom checklist by a National Institute of Mental Health (NIMH) task force [21]. Alcoholism was measured by the Short Michigan Alcoholism Screening Test [22], and drug abuse was assessed by questions adapted from the Periodic Evaluation Record—Community version [21]. Clients were also asked questions about their criminal history.

Clients were asked questions regarding their utilization of mental health services and other social services, including income assistance, housing, employment, and general health care. They were also asked how willing they were to use such services in the future.

Informal social support was assessed by the Arizona Social Support Interview Schedule [22]. Three scores from that instrument were used in the present study: total support available, total support utilized, and felt need for additional support. An alienation scale adapted from Bahr & Caplow's [23] study of homeless people was administered. Self-esteem [24] and quality of life [25] were also assessed, using previously published scales.

For many of the measures, comparative data on other homeless samples or the general population existed, so that it was possible to reach some tentative conclusions about the lives of the St. Louis homeless population relative to other groups.

Statistical analysis

When possible, parametric statistical procedures (analysis of variance) were performed. Scheffee's procedure was used to identify which groups were significantly different from every other. Chi-square analyses were used, with categorical dependent variables; differences at the 0.05 level were considered significant.

Results

Psychiatric history

One-fourth (25.0%) of the homeless people had previously been hospitalized for mental disorders. In the vast majority of these cases (73.8%), mental hospitalization had preceded the initial homelessness.

The mean number of prior hospitalizations was 4.1 (S.D. = 5.3), although the range varied greatly, from 1 to 29 previous hospitalizations. The mean period of longest hospitalization was 5.6 months (S.D. = 15.5 months); the mean length of time since most recently hospitalized was 49.2 months (S.D. = 62.0 months).

In addition, another 16.1% of the sample had received some type of past outpatient treatment. Thus, 41.1% of the total sample had previously received some form of mental health treatment.

Current mental health care. Only 15.3% of the sample were currently receiving some form of mental health treatment or service. For persons who had in the past but currently were not receiving care, the mean length of time since the last treatment was 46.3 months (S.D. = 54.7).

Types of mental health care. The 41.1% of the total sample who had had mental health treatment were asked whether they (*a*) were currently receiving, (*b*) had previously received, or (*c*) had never received four specific types of mental health care. The results are shown in Table 1.

As shown, psychiatric medication and counseling or psychotherapy were the most frequently received mental health services. It is noteworthy that few of the homeless had ever received the more innovative community support and rehabilitation services of day programs or, especially, residential programs.

Current mental symptoms. Almost one-half (46.9%) of the homeless people scored above the screening cutoff score of 0.72 on the Global Severity Index of the BSI (mean = 0.84, S.D. = 0.60). Compared

Table 1

Percent of Homeless as Recipients of Mental Health Services, by Type of Service

Treatment/ service	Currently receiving	Previously received	Never received	Total
Psychiatric medication	26.0	38.5	35.6	100.1
Counseling or psychotherapy	27.9	52.9	19.2	100
Day treatment program	6.7	19.2	74.0	99.9
Residential program	—	12.6	84.4	100

with the nonpatient population, our sample of homeless people displayed elevated levels of mental symptoms on all subscales of the BSI. Most marked were symptoms of paranoid ideation and psychosis. Sixty-two percent of the homeless people scored above the cutoff point that suggests psychiatric disturbance for paranoid ideation, and 54% were above the cutoff score for psychoticism. The elevation of these two particular symptom categories indicates the serious nature of the mental problems experienced by homeless people.

Categories of mental health needs

The entire sample was classified into one of three categories of mental health need: (*a*) "normal," or no service need (44.3%); (*b*) crisis/acute mental health needs, as indicated by a score above 0.72 on the Global Severity Index and/or one brief, previous mental hospitalization (35.8%); and (*c*) chronic mental health needs, characterized by a history of multiple and/or lengthy (three months or longer) mental hospitalization (19.9%).[5]

Mental symptoms. Not surprisingly, homeless persons within the two mental health groups (acute, chronic) exhibited far higher overall symptom levels of psychopathology than did the normal homeless category ($F(2,243) = 106.02$, $P < 0.001$). The acute and chronic

Table 2

Percent of Homeless Receiving Mental Health Treatment

Receiving service	Normal need	Acute need	Chronic need
No	99.1	89.7	42.9
	(N = 108)	(N = 78)	(N = 21)
Yes	0.9	10.3	57.1
	(N = 1)	(N = 9)	(N = 28)
Total	100	100	100

categories did not differ significantly from each other in overall level of symptoms.

The self-esteem of the chronic and acute groups was lower than that of the normal group ($F(2,243) = 12.63$, $P < 0.001$).

Current service contact. The percentage of homeless people currently receiving mental health treatment or service is shown in Table 2 for each of the three groups. The differences are significant ($\chi^2(4) = 84.29$, $P < 0.001$). Of particular interest is the difference between the acute and chronic categories. More than one-half (57.1%) of the chronic group are currently receiving some form of mental health care whereas few (10.3%) of the acute group are under treatment.

Service willingness. When service willingness was considered a dichotomous variable, the vast majority (83.7%) of the chronic group indicated some willingness to receive mental health care; 59.9% of the crisis/acute group and 40.4% of the normal group were also interested in mental health services. Homeless people with acute or chronic mental health needs were far more willing to receive mental health care than the normal group ($F(2,243) = 20.39$, $P < 0.001$). Also, persons with chronic problems were more willing to receive mental health care than were those in the acutely ill group.

As mentioned above, persons in the two mental health need groups were referred for additional treatment. Ninety of the 137 people in

Table 3

Percent of Homeless Requesting Various Referral Services

Service	Service requested	
	Yes	No
Community placement evaluation and referral	82.6	17.4
Other housing assistance	74.1	25.9
Psychiatric medication	25.0	75.0
Referral for other outpatient or inpatient mental health services	34.5	65.5
Day program (Shamrock Club)	55.8	44.2
Case management	68.2	31.8
Other health and social service evaluation and referral	37.7	62.3

these two groups indicated an interest in receiving some kind of mental health service. Table 3 displays the percentage of this subsample interested in each type of care. It is noteworthy that a large percentage of the respondents were interested in placement in community residential services, housing assistance, day treatment, and case management, but few were interested in more traditional psychiatric treatment.

Alcoholism/drinking problems. About one-third (35.5%) of the homeless people appeared to have drinking problems or alcoholism, as determined by their scoring at or above the cutoff mark on an alcoholism screening test; 35.1% of the total sample indicated a willingness to receive treatment for drinking problems or alcoholism. Few of the homeless (5.7%) were currently receiving treatment for alcoholism or drinking problems, although an additional 15.4% had received treatment in the past.

The chronically mentally ill group had significantly greater drinking problems than either the crisis/acute or the normal group ($F(2,243) = 10.46$, $P < 0.001$). Sixty-one percent of the chronic group scored above the alcoholism cutoff point compared with 29% in the other two groups. Although the chronic group indicated that they were somewhat more willing to receive alcoholism treatment than the other two groups, the difference was not significant ($F(2,245) = 2.66$, $P < 0.07$).

Drug use/abuse. Nonalcoholic, nonprescribed drugs had been used in the preceding month by about one-fifth (20.8%) of the homeless. By far the most frequently used drug was marijuana (by 80.4% of those who used drugs). The frequency of drug use varied widely, from daily (29.1% of the drug users) to less often than once a week (16.4% of the drug users). Nearly 20% of the total sample rated themselves as having a drug problem.

Although there was no difference in drug use as a function of mental health need group ($\chi^2(2) = 4.05$, $P < 0.13$), the chronic need group was more likely to rate themselves as having a drug problem ($F(2,239) = 7.63$, $P < 0.001$) than the other two groups. However, on a scale from 0 (no problem) to 4 (severe problem), the mean for the chronic group was only 0.82 (S.D. = 1.48).

Other human service needs

In addition to mental health care, the homeless population, particularly the chronic mental health need group, is in need of a number of other services. Some of these are documented below.

Physical health. About one-half (50.4%) of the homeless people reported having one or more physical problems diagnosed in the previous year. The most commonly diagnosed health problems among the homeless were high blood pressure (16.9%), arthritis (10.9%), and anemia (10.5%). The chronic group (mean = 1.37, S.D. = 2.03) had significantly ($F(2,243) = 8.53$, $P < 0.001$) more medical problems than the acute (mean = 0.61, S.D. = 0.89) or the normal group (mean = 0.53, S.D. = 0.94). In a random sample of San Francisco area residents, Moos and colleagues [20] reported a mean of 0.47 (S.D. = 0.84). Thus, it is the chronic mental health need group whose medical problems are the most apparent, at a rate far higher than that of the general population.

The vast majority of the sample (87.6%) indicated some willingness to receive better medical service. There was no significant difference by mental health need group ($F(2,243) = 1.39$, $P < 0.68$). Only about one-fourth (26.2%) of the homeless, however, were currently under the care of a medical professional. The length of time since the last medical contact for the entire sample ranged widely, from 1 day to 12 years, the mean length of time being 14.9 months (S.D. = 25.5 months). People with no mental health needs received less medical treatment ($\chi^2(2) = 10.63$, $P < 0.005$).

Housing. The majority (64.4%) of the homeless people had spent every night of their current episode of homelessness in shelters; however, 35.6% of the sample had spent at least some nights "on the streets" (e.g., parks, bus depots). The percent of time spent in the shelters did not vary as a function of mental health need group ($F(2,242) = 1.28$, $P < 0.28$).

The vast majority of homeless people (96.8%) were willing to receive assistance in obtaining permanent housing. Despite such a great willingness for service on the part of homeless people, only a minority of them were actually receiving current help in obtaining housing. Shelter, local, state, and federal agencies were assisting only about 1 in 5 (21.8%) homeless people in finding permanent housing. Mental health need did not affect whether one was receiving housing assistance ($\chi^2(4) = 1.17$, $P < 0.88$).

Employment and job training. About 9 of every 10 homeless (90.7%) people were currently unemployed. The mean length of the current period of unemployment was 23.36 months (S.D. = 30.74 months).

Although 93.1% of the sample were willing to receive assistance in obtaining employment, only 1 in 5 homeless people (20.6%) was actually receiving current assistance in finding a job from any type of agency or shelter.

The job skills of these homeless people were concentrated at the lower levels of the occupational ability ladder. Almost two-thirds of them had been either semiskilled (35.6%) or unskilled (28.3%) workers in their most recent employment. Only 10.9% of the sample was receiving job training, even though 91.9% said they were willing to participate in such programs.

There were no differences as a function of mental health need group in the employment-related variables with the exception of services from the Vocational Rehabilitation Department, which favored the normal group ($\chi^2(4) = 25.16$, $P < 0.001$).

Income/financial assistance. The amount of income in the previous week for almost two-thirds (62.1%) of the homeless had been nil. The mean weekly income was $24.42 (S.D. = $56.40). Although 75.6% of the sample were willing to receive financial assistance, only a minority of the homeless were currently receiving such aid. General relief, Aid to Families with Dependent Children, or other welfare programs were currently providing funds to 23.0% of the homeless. Social Security programs provided current income to a few of the homeless, 7.3% receiving SSI payments, and 0.8% receiving some other form of Social Security payment. Fewer than one in ten was receiving some form of assistance from the Employment Securities (Unemployment) Office. There was no difference in income assistance as a function of mental health need group.

Legal/criminal justice system problems. About one-fifth (21.6%) of the sample had been arrested at some point while they were homeless, and 1 in 10 of the total sample had been convicted of a crime and imprisoned while homeless. The most common offenses were drunkenness, aggravated assault, drug abuse violations, burglary, and larceny. The chronic mental health need group was significantly more likely ($\chi^2(2) = 16.99$, $P < 0.001$) to have been involved in criminal activity (45.8%) than the acute group (17.4%) or the normal group (17.9%).

Informal social support

The preceding data clearly indicate that the homeless population has a multitude of needs that are not being met by the formal social service system. Moreover, the homeless are also lacking informal sources of social support. Only 4.4% of the homeless sample were currently married and living with a spouse. Over half (52.4%) had never been married; 20.2% were currently separated; 14.1% were divorced; 4.8% were widowed; and the remaining 4% were married, but living apart because of the unavailability of shelter space for couples. There were no differences in marital status as a function of mental health need ($\chi^2(10) = 9.78$, $P < 0.46$). There were no differences as a function of mental health need in terms of either support available

($F(2,239) = 1.03$, $P < 0.36$) or support utilized ($F(2,239) = 1.41$, $P < 0.25$). However, both the chronic and the acute mental health groups reported needing more support than the normal group ($F(2,239) = 18.78$), $P < 0.001$).

Although adult norms are not available for social support scales, three studies using adult women and undergraduate students [26-28] found that the mean amount of social support available was between 10.32 and 10.87, which is about twice as much as the support reported for our sample of homeless people (5.33).

Consistent with previous research on the homeless, all of our homeless people were quite alienated. Table 4 contains the mean alienation scores for St. Louis homeless subsamples and comparative data from a study by Bahr & Caplow [23]. As shown, the percentages for the St. Louis homeless subsamples are very similar to those found in two homeless groups (a shelter group and a residential camp) by Bahr & Caplow. In our sample we found no differences in alienation and mistrust as a function of mental health need group ($F(2,243) = 0.36$, $P < 0.70$).

In summary, our data have demonstrated that informal sources of social support as well as formal sources are lacking for the homeless.

History of homelessness and impact on well-being

In the previous sections we have documented the mental and other human service needs of the homeless population. We have shown that homeless people lack both informal social supports and support from the social service system.

In this section we present information on crisis events that preceded the initial episode of homelessness and some more specific information on the history of homelessness. We conclude with an assessment of the quality of life of our homeless sample.

Negative life events. In the year before they became homeless, the St. Louis homeless people were exposed to significantly more negative life events (mean = 4.46, S.D. = 2.44) than Moos and his co-workers [18] found in the general population (mean = 1.35, S. D. = 1.50)

Table 4

Mean Alienation Scores*

	St. Louis		Bahr & Caplow [23]
Total	0.715	Shelter homeless	0.748
Normal	0.699	Camp homeless	0.676
Acute	0.725	Poor controls	0.680
Chronic	0.733	Wealthy controls	0.332

*Five items were scored 0-1, 1 indicating alienation or mistrust. The values in the table represent mean scores on those five items for each group of the sample.

or in a depressed patient sample (mean = 2.40, S.D. = 2.02).

Unemployment (78.9%), loss of income (58.5%), debt (45.6%), fired from job (35.9%), death of a friend (32.3%), and assault (28.7%) were some of the more common negative events for these people. The chronic mental health group (mean = 5.43, S.D. = 3.07) had suffered significantly ($F(2,236) = 5.19$, $P < 0.006$) more negative life events than the normal homeless group (mean = 4.07, S.D. 2.20). The acute group's mean of 4.40 (S.D. = 2.21) was not significantly different from that of the other two homeless groups.

Sexual abuse was not one of the items in the original life events scale, but we did think it important to ask respondents about sexual abuse since they had become homeless. The chronic group (20.4%) had been sexually abused more frequently ($\chi^2(2) = 18.19$, $P < 0.001$) than the acute group (9.2%) and the normal group (0.9%).

History of homelessness. Homelessness has become perpetual for many of the sample, particularly the chronic group. The chronic mental health need group had significantly ($F(2,243) = 6.13$, $P < 0.003$) more episodes of homelessness (mean = 3.82, S.D. = 3.61) than either the crisis/acute (mean = 2.15, S.D. = 1.84) or the normal group (mean = 2.39, S.D. = 2.98). Although the chronic group's current episode of homelessness tended to be longer in months (mean = 22.46, S.D. = 37.01) than that of the crisis/acute group (mean = 13.13, S.D. = 27.42) or the normal group (mean = 12.60, S.D. = 22.43), the differences were not significant ($F(2,243) =$

2.39, $P < 0.09$). However, the number of months since first homeless was significantly greater ($F(2,243) = 7.34$, $P < 0.001$) for the chronic group (mean = 58.60, S.D. = 57.35) than for the acute group (mean = 26.35, S.D. = 43.41) or the normal group (mean = 27.03, S.D. = 56.01).

Quality of life. Given the misfortunes of the homeless, it is not surprising that they experience a poorer quality of life than the general population. Table 5 provides a comparison of our sample of homeless people with data on the general population [29]. As the table indicates, the chronic mental health group reports the lowest quality of life of the St. Louis homeless sample. Furthermore, comparative data from Baker & Intagliata [25] suggest that the St. Louis homeless chronic patients experience a poorer quality of life than a sample of Community Support Program clients from New York in 10 of 14 life areas. Community support programs may result in a higher quality of life for chronic patients than that experienced by chronic patients who frequent shelters, but other explanations for the observed differences in quality of life (such as different psychiatric treatment histories or more severe pathology) may be plausible.

Discussion and service implications

The identified rate of psychiatric hospitalizations and mental health need in this study is somewhat less than what has typically been reported [7,9,30]. The differences may, in part, reflect local differences, although it should be remembered that the current study, unlike previous ones, employed a random and representative sample, a methodological feature that allows for more accurate generalizations to the larger population of homeless people. It is noteworthy that our current study found a lower rate of prior mental hospitalization than an earlier study that we conducted in St. Louis that used a sample of convenience from a single shelter.[6] It appears that studies based on nonrandom and single-setting samples may significantly bias the estimates of the larger population (note also that the subjects in the 13 shelters in the current study varied in the rate of prior mental hospitalization from 0% to 42.0%).

Table 5

Quality of Life Comparisons[a]

Life domain satisfaction question	Nonhomeless general population[b]	Total sample	St. Louis Study: Homeless need category Normal	Acute	Chronic	Nonhomeless: Community Support Program, chronic group[c]
1. Place staying at ("residence," i.e., shelter)	5.3	4.77	4.57	5.20	4.40	5.51
2. Neighborhood	5.4	4.10	4.00	4.27	4.00	5.38
3. Food	—	4.81	4.74	5.08	4.47	5.37
4. Clothing	—	4.68	4.69	4.84	4.34	5.17
5. Health	—	5.35	5.83	5.29	4.38	4.75
6. People live with	—	4.66	4.63	5.01	4.00	5.59
7. Friends	5.6	5.55	5.77	5.45	5.21	5.65
8. Family	5.7	4.48	4.89	4.19	4.09	5.16
9. Interpersonal relations	5.7	5.56	5.69	5.64	5.11	5.46
10. Job/work/day	—	4.45	4.26	4.72	4.38	5.27
11. Spare time	5.4	4.54	4.70	4.52	4.21	5.10
12. Community recreation	—	4.84	5.01	4.81	4.51	4.82
13. Area services and facilities	—	4.87	4.63	5.22	4.77	5.25
14. Economic situation	—	2.63	2.57	2.83	2.40	4.56

[a] Higher scores indicate higher quality of life.
[b] Data from Andrews & Withey [29].
[c] Data from Baker & Intagliata [25].

These points are not intended to imply that the current study has determined the definitive rate of mental disturbance among all homeless people. As suggested elsewhere [13], the data for making such a claim would need to be based on systematic sampling of the entire universe of homeless people—a formidable task indeed. Alternatively, reports such as ours, which are based on regional representative samples, will collectively help to determine a more reliable answer to the question of the rate of mental disturbance among the homeless.

These methodological issues should not obscure the pressing policy implications of the data. The basic conclusion from our results is consistent with that in other papers: the needs of the homeless population are not being adequately met by either the mental health system or the larger network of human services. The fact that mental hospitalization *preceded* homelessness for 73.8% of those ever hospitalized, coupled with the lengthy periods of homelessness and recurring episodes of homelessness (particularly for the chronic group), is further documentation of the failure of deinstitutionalization policies without adequate community support services. It is also clear that the vast majority of the homeless are below the "safety net" of social welfare services. Few of the homeless received needed social services, particularly in such critical areas as housing assistance, employment assistance, and financial aid. This suggests that the social welfare system is woefully inadequate for the needs of the homeless.

In contrast to the level of care, willingness to accept assistance was quite high for a range of services, including mental health treatment. It is important to note, however, that the homeless people in our study were more interested in community support services [31] than traditional psychiatric treatment. Although their apparent willingness to use human services is contrary to prevailing professional concepts of the homeless as apathetic and resistive to treatment, our findings are consistent with Arce and colleagues' [9] findings of high service utilization rates for residential placements (70%) and compliance with psychiatric medication (86%) and observational accounts of the willingness of the homeless to accept service [15].[7]

Another conclusion from our study that differs from the previous literature is that homeless people with mental health problems are not a single group. The emphasis of previous papers has been on homeless people with chronic problems, and it has recently been recommended that the mental health system limit its concern to homeless persons with serious, chronic, mental illness [13]. We found, however, that one-third of the homeless had significant crisis or acute mental health needs. Persons in this category lacked the history of mental health system involvement that is characteristic of the classic or the "new" [32-34] chronic mental syndrome. Yet these people had markedly high levels of mental/emotional disturbance, and they were currently receiving few mental health services. It seems reasonable to speculate that without additional services, the psychological functioning of some of the people in this category is likely, eventually, to deteriorate to a chronic state; all of these people were at present experiencing acute emotional distress.

As expected, we found that people with chronic mental disturbance also constituted a significant—and especially troubled—subpopulation of the homeless. The chronic mental health need group was noteworthy among homeless people for their multiproblem nature. Not only did the chronic mentally disturbed have repeated and/or lengthy hospitalization histories but they were also more likely to be beset with other difficulties: substance abuse, sexual abuse, poor physical health, and criminal problems. Compared with other homeless groups, they experienced higher levels of stress, were homeless longer and more often, and, not surprisingly, suffered the worst quality of life. The chronic group most clearly symbolizes the failures of deinstitutionalization and the inadequacies of the existing mental health service system.

Clearly, additional mental health services need to be provided for both homeless groups, i.e., people with crisis/acute mental health needs and those with more chronic mental disorders. Services available to both groups should include crisis counseling, psychotherapy, and psychiatric medication. To be maximally effective, such services should be developed specifically for the homeless and should be provided on an outreach, community basis. Indirect services of consultation and education to shelter organizations have also been beneficial in some areas.[8] For homeless people with chronic mental health needs, additional community support services of case management, day programs, and, especially, residential services are an even greater service priority.

The importance of residential care for the mentally disturbed homeless cannot be overemphasized. Although in our larger study we found that day programs, outreach services, and traditional mental health services were effective in improving individual psychological adjustment, they did not enable homeless persons to achieve a "nonhomeless" status.

Residential programs need to consider the special characteristics of the chronically mentally disturbed, particularly alcohol abuse, episodic acting-out behaviors, "resistant" personalities, and a strong desire for autonomy [8,9,13,35]. The Fairweather Lodge program [36,37] seems a particularly promising model of mental health residential service for such clients, given its emphasis on client autonomy, employment, and social support.

If the quality of life for homeless persons is to be substantially enhanced, major changes are required not only in the mental health system but also in other human service agencies. The current system of care for homeless persons is fragmented, with very little coordination among the agencies that are trying to serve the homeless population. What is needed is a publicly mandated and financed comprehensive service system for homeless people. A new organization, homeless resource centers,[9] would be useful in this context. Such centers would be located close to shelters, and would employ outreach staff who were knowledgeable about a range of resources. More importantly, these outreach workers would have to be comfortable with nontraditional methods of interacting with clients, particularly "street work."

In sum, although the mental health system shares considerable responsibility for providing services to homeless people who have mental health needs, it is clear that homelessness is a multidimensional problem that requires coordination with other human service resources.

Acknowledgment

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Assuming, however, that self-report measures of willingness to accept services are relatively accurate in reflecting homeless clients' interest in human services, more detailed research is needed to document why homeless clients and potential professional helpers fail to make connections. Are homeless clients referred for help? Do they call agencies for appointments? Are they kept waiting for long periods in crowded waiting rooms? Do they walk out because of frustration? If seen by human service staff, are they declared ineligible for services because they lack a permanent address? Do the homeless discern prejudice against them on the part of agency staff? To answer these and related questions, detailed tracking research, probably based on participant observation research techniques, needs to be conducted on a representative sample of homeless people.

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PREPARED STATEMENT OF CHRISTINE NYE

Mr. Chairman and members of the Committee: I am pleased to be here this morning to discuss concerns for our nation's homeless mentally ill citizens.

INTRODUCTION

Estimates of the number of homeless individuals in the United States vary widely. Different studies project that there may be between 560,000 to 735,000 homeless persons on any given night. Approximately one-third of this population suffers from severe mental illness and about half of these individuals are alcohol and/or drug abusers.

Many Federal programs currently address the needs of the homeless population. These fall into two basic categories: programs targeted specifically at the homeless, and mainstream programs that include the homeless in the populations they serve. Programs within the Department of Health and Human Services (DHHS) and the Department of Housing and Urban Development (DHUD) assist homeless mentally ill individuals by providing a range of services from food and shelter to coordination of cash and medical assistance benefits. Outreach efforts are also underway to ensure that eligible recipients receive the care and services to which they are entitled.

HOMELESS MENTALLY ILL OUTREACH ACT

S. 62 would require States to operate outreach programs specifically targeted at the homeless mentally ill in metropolitan areas. The bill requires mobile teams of mental health professionals to identify the homeless mentally ill and arrange for their transportation, involuntarily if necessary, to treatment referral centers. States would be required to provide not only medical services, but also temporary room and board and other social services. S. 62 would have all these services paid for by the Medicaid program for at least 30 days, regardless of whether the homeless individual is eligible for Medicaid.

We appreciate the concern for the plight of our Nation's homeless mentally ill citizens embodied in this bill. However, S. 62 raises several significant concerns. Foremost among them is the imposition of another Medicaid mandate. As you know, the Medicaid program is consuming increasingly larger portions of State budgets and was the second largest State spending category in fiscal year 1990. Recent Medicaid mandates will cost almost $6 billion in Federal and State spending over the next 5 years. A growing number of individuals receiving cash assistance also adds to the Medicaid rolls. We've all heard that States are unable to keep pace.

Given that both Federal and State resources are scarce, the Administration supports the National Governors' Association request for no new mandates for Medicaid expansions. In this climate of fiscal constraint, we need to work with States to better manage available resources for existing programs before we undertake new initiatives.

We are also concerned about the potential cost of S. 62. In the absence of reliable information on the homeless population, it is difficult to assess the impact of this bill. However, our actuaries indicate that the Federal expenditure alone for S. 62 could cost up to $1 billion annually. This amount is significant and unreasonable given the current deficit situation.

In addition, S. 62 would expand the Medicaid program to a broader purpose than its current mission. It expands eligibility without regard to other qualifying criteria which define the Medicaid population as those receiving cash assistance through the Aid to Families with Dependent Children and Supplemental Security Income programs, and pregnant women and children up to age 6 in families with incomes up to 133% of the federal poverty level.

S. 62 would target a substantial amount of spending on a relatively small population which is already receiving considerable attention and assistance from a broad range of public and private sector organizations. S. 62 would, in many respects, duplicate current activities to aid the homeless and would further fragment efforts on their behalf. The National Commission for the Homeless Mentally Ill proposed in S. 62 is a case in point. It would duplicate the efforts of the Department's Task Force on Homelessness and Severe Mental Illness to develop recommendations that address the needs of this population.

PROGRAMS TARGETED TO THE HOMELESS

The Department of Health and Human Services will spend $232 million in fiscal year 1991 through grant programs targeted to serve the needs of our homeless citizens. The Public Health Service administers several of these programs, including:

> The *Health Care for the Homeless Program* (HCH) serves severely mentally ill, homeless people and links them to mental health treatment services. HCH projects are the largest providers of primary health care to the homeless mentally ill. They also provide substance-abuse services, emergency health services, referrals to necessary hospital services, aggressive outreach and case management services, and assistance establishing eligibility for and obtaining benefits under entitlement programs. There are 109 projects currently receiving HCH grants located in 103 cities and 43 states. In 1989, over 350,000 homeless individuals were served by Health Care for the Homeless program.
>
> The *Project for Assistance in Transition from Homelessness Program* will provides comprehensive health services, including outreach and case management, to homeless individuals suffering from severe mental illness and/or substance abuse disorders. Up to 20 percent of this funding can be used for services to obtain housing or otherwise prevent homelessness.

The Department's new Administration on Children and Families administers the Emergency Community Services Homeless Grant program and three programs serving runaway and homeless youth.

Further, the Administration has requested Congressional funding for a new *Shelter Plus Care* program in the Department of Housing and Urban Development authorized by the National Affordable Housing Act.

MAINSTREAM DEPARTMENT PROGRAMS

In addition to targeted programs, three major, mainstream programs within the Department of Health and Human Services also include the homeless in the populations they serve.

Medicaid contributes nearly $200 million a year in health care services to the homeless. The mentally ill homeless typically become eligible for Medicaid by qualifying to receive Supplemental Security Income disability benefits. They may also become eligible for Medicaid by meeting standards for State medically needy programs.

States are prohibited from imposing residency requirements on individuals without permanent addresses as a condition of Medicaid eligibility. States must also provide a method for making Medicaid cards available for persons without a permanent address. HCFA pays States for outreach efforts necessary to accomplish this.

State Medicaid agencies are required to perform certain outreach activities, including making information available to applicants. Additionally, funds are available for most outreach programs that a State may develop.

In New York, for example, State activities range from subway advertising for managed care to posters in rural post offices. New York also provides targeted case management under Medicaid for over 5,000 mentally ill who are homeless and live on the streets or in shelters. The goal of this effort is to reduce hospitalization and reliance on emergency psychiatric services for these individuals.

The Supplemental Security Income (SSI) program, administered by the Social Security Administration, provides cash payments to low-income aged and disabled persons. Many States have the Social Security Administration make automatic determinations of Medicaid eligibility when they approve SSI benefits for individuals.

SSA has developed a comprehensive SSI outreach strategy that provides information about the SSI program, encourages potential eligibles to apply for benefits, and assists people through the application process. SSA's outreach effort is integrated with local community-based programs that provide support and services as well as other HHS medical assistance, social services, and rehabilitation programs.

Under the leadership of SSA Commissioner Gwendolyn King, SSA field offices have established various outreach activities and special procedures to meet the problems faced by the homeless in obtaining the Social Security or SSI benefits for which they are eligible.

- Directories of services have been published and distributed to shelters and local social service agencies;
- SSA managers and employees work with local shelters to help SSA serve the needs and protect the rights of the homeless by assuring representation in the claims process and working out check delivery problems;
- Contact stations have been established in shelters in many cities;

- Local programs have been developed, in conjunction with other agencies, to actively seek out homeless people and maintain contact with them during the processing of SSI claims; and
- Pre-release arrangements with local public medical and domiciliary institutions have been strengthened to better identify potential homeless situations.

SSA also funded 25 outreach projects under an FY 90 SSI outreach demonstration project. Of these 25 projects, several target the homeless in both urban and rural areas.

Another mainstream program, *the Alcohol, Drug Abuse, and Mental Health Services Block Grant,* provides funds to States for community-oriented mental health, drug, and alcohol services.

TASK FORCE ON SEVERE MENTAL ILLNESS

In May of 1990, Secretary Sullivan established a Task Force on Homelessness and Severe Mental Illness. The Task Force has a broad mandate to examine the systemic problems that make severely mentally ill people particularly vulnerable to homelessness. The Task Force will review research findings and solicit advice to determine:

- effective methods for providing treatment and coordination of appropriate services;
- the prevalence, causes and treatment of major mental illnesses;
- the prevalence, causes and approaches to preventing homelessness among severely mentally ill persons; and,
- factors that impede access to housing, mental health, income support, and human service programs.

Recommendations outlining a course of action are expected to be submitted to the Federal Interagency Council on the Homeless by January 1992.

THE INTERAGENCY COUNCIL ON THE HOMELESS

The Interagency Council on the Homeless was established by the Stewart B. McKinney Act of 1987. The Council is chaired by the Secretary of HUD, Jack Kemp. Secretary Sullivan serves as Vice Chairman and 16 Federal agencies participate in council activities which include planning and coordinating Federal homeless programs; reducing program duplication; recommending improvements; and, reporting annually to the President and Congress on the extent and nature of homelessness. Several Interagency Council agreements, contracts and publications provide technical assistance to States, local governments and other public and private voluntary organizations. These activities include targeting providers, collecting and reviewing existing data, developing alternative financing, and coordinating services.

MENTAL HEALTH SERVICES DEMONSTRATIONS

As part of a joint HUD-HHS memorandum of understanding signed last year, HHS has funded 6 demonstration projects totalling $6 million in fiscal year 1991 to test various types of HUD-provided housing assistance combined with treatment and services for severely mentally ill homeless people.

PRIVATE/PUBLIC SECTOR INITIATIVE

Other programs contribute a variety of services for the homeless. An example of a fine public/private sector initiative was initiated by the Robert Wood Johnson Foundation in conjunction with HUD and HHS which supports community-wide projects aimed at better coordination and expansion of services and housing for people with chronic mental illness, many of whom are homeless. These projects provide a broad range of services and housing options to help people function more effectively and avoid inappropriate institutionalization.

CONCLUSION

The Federal government is contributing substantial time, energy, and resources to address the multiple and complicated issues of homelessness in America. Our Nation's public and private sector involvement with this difficult-to-reach population testifies to the compassion and willingness of leadership to address this difficult problem.

We need to consider carefully the reports of the Department's Task Force and the Interagency Council on the Homeless before advocating costly changes that ultimately may not further our objectives. We need to get a clearer picture of the scope and extent of the problem and an idea of solutions that will work in meeting the health care needs of the homeless mentally ill.

To expand the Medicaid program, as proposed in S. 62, may be unnecessary and may serve only to further frustrate the coordination of needed services for the homeless mentally ill. Medicaid is the Nation's principal health care program for the poor. It provides very basic health care benefits and is not designed to address specific groups' problems in a piecemeal manner. Public Health Service programs are designed to target special needs and special populations and should continue to be the major vehicle for assisting the homeless.

Thank you. I would be happy to respond to any questions you might have at this time.

PREPARED STATEMENT OF LEE PARTRIDGE

INTRODUCTION

Mr. Chairman, members of the Committee, I am Lee Partridge, Director of the Washington, D.C. Office of Health Care Financing. I am here today representing the State Medicaid Directors' Association of the American Public Welfare Association. I thank you for the opportunity to speak today on S. 62, the "Homeless Mentally Ill Outreach Act of 1991," sponsored by Senators Moynihan and Danforth.

Addressing the needs of the homeless mentally ill is an important issue for our society. I would like to express appreciation to Senators Moynihan and Danforth for the consideration they have given to the issue and their overall concern about how best to serve those in need. While I and other members of the SMDA do not profess to be experts in treatment of the mentally ill nor the subpopulation of homeless mentally ill, I am intimately familiar with the Medicaid program—its successes, its potential, and its limitations. It is from this area of expertise that I wish to speak to you today.

State Medicaid directors strongly support improving access to health care services for all Americans and particularly for vulnerable populations including the homeless mentally ill. We do, however, have some broad concerns about the proposed legislation, S. 62, as well as some technical considerations we would like to raise.

PROGRAM FLEXIBILITY

As I am sure you are all aware, state Medicaid directors, human service administrators, and the nation's governors have serious concerns about further Congressionally mandated Medicaid expansions. The program is stretched to the limit and beyond in far too many states today. The simple reality is that additional mandates will mean reductions in optional Medicaid eligibility or services in many states. If not in Medicaid, the reduction will occur in some other vital area of human service. Here in the District, we have just decided to sharply reduce our locally funded medical assistance program. States are undergoing difficult service reductions and cost containment measures such as reducing the amount of Medicaid covered services or dropping some optional services altogether. The recession, coupled with greatly increased costs, have left most states in a very weak position.

Given state fiscal concerns, I believe state agencies would more readily support S. 62 if it was constructed as a state option and provided the flexibility to target areas of greatest need. For example, if emergency services to the homeless mentally ill were an option under Medicaid and if the bill permitted a state to target these services to urban areas experiencing the greatest problem (rather than all urban areas), states could make rational resource decisions that might not entail sacrificing other needed services. Through targeting, a state could get a better understanding of the true cost experience and program effectiveness before launching a statewide effort.

SERVICE CONCERNS

S. 62, as currently written, raises some service-related questions. There seems to be a general consensus in the policy community that the root cause of homelessness is lack of affordable housing and for the homeless mentally ill, the root cause is lack of a continuum of care in the community that can appropriately address the needs of this subpopulation. Expansion of Medicaid services can assist the homeless mentally ill but cannot adequately resolve the most central issues.

As federal block grants for community mental health services have declined, the support systems have dwindled. If S. 62 were enacted, we might find states developing Individual Treatment Plans (ITPs) but lacking adequate resources to implement those plans. General service capacity would remain a concern even after enactment of S. 62. While Medicaid would pay for temporary room and board, an adequate supply of appropriate facilities would likely remain a question at least in the short run after a mandate was imposed. Alter the initial 30 days of eligibility allowed under the bill, community resources to provide the appropriate range of services and living arrangements needed could still remain unassured. Offering Medicaid funding for the front-end services as an option, rather than a mandate, would be desirable since it would permit orderly development of needed community-based services to supplement the emergency services to be covered under the Medicaid program.

While federal funding of community mental health services has declined, states have tried to fill the gap using Medicaid in some cases. Much of what is specified in the this bill can already be (and is) funded under the current Medicaid program. In the District, we intend to use the Medicaid rehabilitative services option to fund mental health teams to provide assessment and treatment services in any appropriate setting. D.C. and other Medicaid programs fund transportation, psychiatric services and assessments. Some states fund assistance and referral services through case management. What we cannot do is fund room and board under Medicaid. Medicaid has tried to fill the gap but the problems persist because they are beyond the ability of the program to resolve, even if we were to pay for temporary room and board.

TECHNICAL ISSUES

Currently, Title XIX bars payment for services provided to individuals between the ages of 21 and 65 who are patients of an institution for mental diseases (IMD). An IMD is defined, among other things, as having 50 percent or more of its residents suffering from mental illness, or the facility holds itself out as specializing in the care and treatment of mental illness. It seems possible that a facility providing temporary room and board, and other services to the homeless mentally ill could be defined as an IMD under certain circumstances and Medicaid could be precluded from making payment to that facility for those services unless existing statute is amended. Without such a change, there is a possibility that one of the major features of S. 62 could be negated.

The IMD exclusion could also affect longer term inpatient or residential treatment expectations for this population after full Medicaid eligibility is established. Current federal instructions specify that there is no Medicaid federal financial participation for services to an IMD client, whether those services are provided in the IMD or elsewhere, unless the client is on convalescent leave or conditional release from the facility. It would seem then that Medicaid cannot pay for any services for a particular client if that client is placed in a residential treatment facility in accordance with a treatment plan. This is an existing limitation of the Medicaid program that affects its ability to address the needs of some portion of the mentally ill population.

A change in the IMD exclusion to accommodate the intentions of S. 62 would conceivably have other ramifications. One possible outcome of a change would be the development, through Medicaid, of a facility-based system of care for the homeless mentally ill—either on a recurrent, episodic basis or as a long term care source for the individual who could have few other alternatives outside the Medicaid funding stream. While this potential outcome may be desirable, the ramifications of this change and its impact on Medicaid as well as other public policy, should be discussed and debated. Should a change be made that lifts the IMD exclusion for the homeless mentally ill, it could raise issues of equity regarding Medicaid treatment of the non-homeless mentally ill generally. If the IMD exclusion is not changed, then the question must be posed: what is the capacity of the system to address the mental health needs of the population on something other than a stop-gap, emergency basis? It is a difficult question, but we need to have some sense of the answer.

I would also like to discuss another limitation of the Medicaid program in serving this population—client eligibility. Medicaid eligibility as prescribed in federal statute is not always easy to establish or to maintain. States have been provided greater flexibility in this area with regard to infants and pregnant women, but determining eligibility tied to SSI is not a simple process for the client or the eligibility worker. Gaining and maintaining eligibility can be difficult for the particular population of homeless mentally ill and can create a limitation to coverage beyond the eligibility period specified in the bill.

Medicaid pays for services for eligible clients. The Medicaid claims payment system is predicated on the identification of a specific eligible client to whom a service was provided. Paying for services for any person brought into an assessment-referral center would pose substantial operational problems within the claims payment system; how would Medicaid pay for services for persons not determined to be Medicaid clients?

A related issue is that of presumptive eligibility. The bill creates a presumptive eligibility category to carry a client beyond the initial 30 days of care through another 90 days of care after an ITP is established. The statutory language is not completely clear whether the presumptive eligibility is an option or a requirement. S. 62 also does not address who would make the presumptive eligibility determination, which may prove problematic since Title XIX currently has some specific limitations on who may do this. Current law relates the presumptive eligibility process to determinations for pregnant women and these "presumptive providers" are not appropriate for the purposes of the service outlined in S. 62.

One possible solution to these various problems could be to allow the states to specify who is qualified to make a presumptive determination for the population covered by S. 62 and to start the presumptive eligibility period at the point where the client is brought to an assessment-referral center. The presumptive period could last for the initial 30 days, with the further option of providing an additional period of 90 days of presumptive eligibility. These changes would greatly facilitate achievement of the goals of the legislation from an operational perspective.

It is clear that the Medicaid program has several significant limitations that impact its ability to serve the homeless mentally ill, many of these limitations are not resolved by this legislation. There are other federal and state programs that are intended to serve this population whose eligibility requirements (and administrative sanctions for errors) are not nearly so complicated and rigorous. Because these programs were designed specifically for the homeless and the homeless mentally ill, they may be better suited to the needs of this population.

Congress has authorized programs tailored to the needs of the homeless through the McKinney Act and subsequent legislation. For example, the Projects for Assistance in Transition from Homelessness (PATH) program provides grants to states for mental health, substance abuse and housing services for the homeless. Health care for the homeless projects offer mental health services or referrals in addition to medical services. Expansion of these programs is needed to assure the availability of services for homeless mentally individuals who do not qualify for SSI and Medicaid, and for those who experience lapses in eligibility. Passage of legislation such as S. 62 should not be viewed as reducing the need for adequate funding of other mental health programs like the McKinney Act to a degree sufficient to accomplish its goals.

CONCLUSION

While Medicaid is not the solution to the broad problems of the homeless mentally ill, the program has a role to play in their care and treatment. As debate on this legislation continues, we would urge consideration of several specific changes.

Most importantly, we would urge that this bill be made into an optional Medicaid service that allows states to target services to those metropolitan areas within it that are most in need. We would also urge that states be allowed to begin the presumptive eligibility period at the point when a person is brought to the assessment-referral center for the initial 30 days of coverage to facilitate payment within the current scope of the Medicaid claims payment system. We would also recommend that states be permitted to designate providers who could make the presumptive eligibility determination to avoid the current constraints of the Title XIX statute. We also request that the presumptive eligibility currently specified in S. 62 be clarified as an option and be changed so that it is an optional 90 day extension of the initial presumptive eligibility we previously recommended. It is likely that the current IMD exclusion will need to be amended so that the assessment-referral center which may provide temporary housing would not fall into the IMD category, thereby making all residents ineligible for Medicaid.

I must stress that enactment of a modified version of S. 62 should not diminish the urgent need to fund programs suited to development of a range of community based outpatient and residential treatment programs suited to the needs of the mentally ill and the homeless mentally ill. We also cannot let passage of a bill such as S. 62 divert us from the central issue of development a stock of affordable housing in this country. Without resolution of these areas of critical importance, we will return again to the need for more emergency measures. These basic problems are chronic and long term in our country and do not lend themselves to easy resolution through emergency measures, however helpful the emergency measures may be in the short run. Structuring S. 62 as an option, rather than as an emergency mandate, would recognize that these problems are long term and chronic in nature and would allow individual states to plan how best to make use of the option so there is the possibility of developing an organized system to work in conjunction with the Medicaid services.

I appreciate the opportunity to discuss these issues and would welcome any questions.

Prepared Statement of Thomas M. Posey

The National Alliance for the Mentally Ill (NAMI) an advocacy organization with 130,000 members consisting of person with mental illnesses and their families, is pleased to submit written testimony in support of S 62, the "Homeless Mentally Ill Outreach Act of 1991."

Serious mental illnesses such as Schizophrenia and Manic-Depressive disorders are far more prevalent in society than most people realize; yet relatively little priority has been given to providing treatment and supports to persons with these illnesses. Today, the number of patients residing in public psychiatric hospitals continues to decrease. Unfortunately, the communities into which these individuals are moving continue to be ill-equipped and/or unwilling to serve them. In many communities, there are few, if any public services available for persons with mental illnesses. Other communities, particularly large cities, are overwhelmed by the number of persons with these illnesses residing within them. This despite the fact that most people with serious mental illnesses *can* live in the community if provided with adequate treatment and rehabilitative services.

The extent to which the lack of available and appropriate community-based services has reached crisis proportions is illustrated by two horrifying statistics. First, there are today over twice as many people with schizophrenia and manic-depressive psychosis living in public shelters and on the streets than in public psychiatric hospitals.[1] There is broad variation in estimates of the number of homeless individuals currently in America. A reputable study conducted by the Urban Institute in 1989 estimated the number of such individuals to be between 570,000 and 600,000.[2] It is further conservatively estimated that about one-third of all homeless individuals suffer with serious mental illnesses. The suffering experienced by these individuals is almost indescribable. Much of this is directly attributable to the active symptoms of their illnesses and the lack of treatment received to abate these symptoms.

Second, there are today more people with schizophrenia and manic-depressive psychosis in jails than in public psychiatric hospitals.[3] The vast majority of these individuals have not committed violent crimes or felonies. Rather, they have been picked up, often from the streets, having engaged in nuisance-type misdemeanors. They are placed in jails because the authorities have no other place to send them. They receive no mental health treatment while in these jails but are eventually released, often back to the streets or public shelters.

Persons who are homeless and seriously mentally ill often have critical needs for basic survival assistance—food, clothing, and housing. Yet after these basic needs are addressed, this group has a need for significant psychiatric treatment and mental health support services. The Homeless Mentally Ill Outreach Act of 1991 represents a positive step towards addressing the comprehensive needs of this vulnerable and highly deserving population. It builds on the approaches used by several successful programs already in existence[4] which are designed to identify and provide services to persons who are homeless and mentally ill.

In many communities, there are far too few programs and resources available to serve individuals with serious mental illnesses who are not homeless. The programs which do exist are often not set up to go out and find individuals who are homeless and mentally ill. As the symptoms experienced by these individuals may be particularly severe during periods of neglect associated with homelessness, it is unlikely, in many cases, that they will seek out services on their own. By authorizing the creation of mobile outreach teams, S. 62 creates an opportunity through the Medicaid program to reach this hard to serve population and provide comprehensive treatment and services. Furthermore, by creating "assessment-referral centers," the bill establishes a mechanism both for providing timely interventions to recipients and to

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[1] Torrey, Erdman, Wolfe, and Flynn; *Care of the Seriously Mentally Ill A Rating of State Programs*, Third Edition, 1990, p. 4.

[2] Burt, Martha R. and Cohen, Barbara E.; *America's Homeless*, 1989, Urban Institute Report 89-3.

[3] Torrey, et al.; *Care of the Seriously Mentally Ill, at p. 6*

[4] Philadelphia has operated such a program for many years and New York has recently initiated a similar program.

link individuals with other programs and benefits in order to build long-term supports to prevent a recurrence of homelessness.

We recommend that the Committee consider the following improvements or clarifications within the bill which will make it fully effective in achieving its objectives.

- **S. 62 should clearly specify that individuals deemed eligible for services through assessment-referral centers be provided coverage under Medicaid both for the new services provided through these centers and for traditional services covered under the particular state's Medicaid formulary.**

The bill appears to create two separate Medicaid funding possibilities: first, a mandatory period not to exceed thirty days of coverage for services provided through assessment-referral centers; second, an optional period of coverage for traditional Medicaid services not to exceed 90 days. NAMI applauds the bill's focus on the need of persons who are homeless and mentally ill to receive health and related services beyond those covered through the assessment-referral centers. What is not clear to us is whether individuals who are deemed eligible for services through these centers will be automatically eligible for the requisite 30 day period for *all* services covered under the state's Medicaid formulary. If not, states which do not opt to find these individuals presumptively eligible under the latter 90 day coverage may refuse to cover traditional Medicaid services, even while paying for the services provided through the centers.

- **If states opt to find individuals identified by mobile outreach team workers as homeless and mentally ill to be presumptively eligible for all Medicaid services, such eligibility should commence on the day those individuals are first identified. This eligibility should remain in effect until the day on which a determination is made as to the individual's Medicaid eligibility, or a maximum of 90 days.**

The first change would enable individuals identified by mobile outreach workers to receive all needed medical and related services immediately upon identification Many of these individuals may be in acute need of such medical services, particularly those who have been homeless for extended periods of time.

The second change would enable these individuals to remain eligible for Medicaid services until a formal determination were made as to the individual's eligibility under existing state standards. Under the current system specified in the bill, it is possible that gaps in Medicaid coverage could occur between a period of presumptive eligibility and a formal finding by the state of Medicaid eligibility for reasons beyond the control of the individual, e.g. the slowness of a particular jurisdiction in processing an individual's Medicaid application.

- **In addition to the services set forth in the bill, assessment-referral centers should be authorized to provide mental health case management services designed to link individuals with needed treatment, services, and housing. Moreover, states should be given the option of adding case management, clinic services, or psychiatric rehabilitation services to the package offered to those individuals found presumptively eligible for Medicaid under this bill, even if the state doesn't generally provide coverage for such services under its Medicaid formulary.**

It is important for states to have the flexibility to tailor the package of services to the individualized needs of each client served through assessment-referral centers. All individuals served by these centers will not have the same needs. Building maximum flexibility into the services offered to these individuals will greatly enhance the chances of achieving successful outcomes.

- **When appropriate, assessment-referral centers should utilize persons who have received treatment for mental illnesses and/or family members of such individuals as staff.**

These individuals are particularly sensitive to the needs of persons who are homeless and mentally ill and have been effectively utilized in a variety of existing psycho-social rehabilitation programs, drop-in centers, and other programs serving persons with mental illnesses.

- **Mobile-outreach teams should be composed of individuals who are trained to provide treatment and assistance to persons with mental illnesses. At least one of these individuals should be a mental health professional.**

Because the intent of this bill is to provide emergency treatment and intervention for persons who are homeless and mentally ill, NAMI believes that the outreach teams should be comprised, whenever possible, exclusively of mental health professionals and others trained to work with persons with mental illnesses.

Although there may be exigent circumstances in which it is necessary to remove individuals from the streets for their own well-being or the well-being of others, the approach of the outreach teams should be, whenever possible, on convincing individuals to accept treatment, not forcing them into treatment. Therefore, if police officers or others authorized to take individuals into custody are included as part of these teams, it is essential that these individuals be trained and sensitized to conduct their activities in a compassionate, humane, and non-punitive fashion. Otherwise, word will get out in the streets that these outreach teams are forcibly removing persons and the intent of the bill to find and provide effective treatment interventions will be defeated.

NAMI agree's with the language in the bill specifying that mobile outreach teams may, when appropriate, initiate involuntary commitment proceedings in accordance with existing state laws. There are times when the severity of an individual's mental illness impacts adversely on the very ability of that individual to make reasoned treatment decisions. However, we believe that involuntary commitment should be a last resort, when members of the outreach team clearly feel that a person meets existing state standards for such commitments and when all other less coercive intervention alternatives have been exhausted.

- **NAMI supports the establishment of a "National Commission for the Homeless Mentally Ill" as specified in Section 4 of S. 62.**

When Congress held hearings to consider deinstitutionalization of persons with mental illnesses in 1963, a system of treatment and services in the community was envisioned as the means for addressing the comprehensive needs of individuals who were to be released from the hospitals. Sadly, such a system has never really materialized. As discussed earlier, this has been a significant factor contributing to the epidemic of homelessness among persons with mental illness today.

Although there is cynicism in the field about "another Commission," we believe that the creation of this Commission makes good sense at the present time. It is essential to evaluate why the comprehensive, community-based systems of treatment and care envisioned by Congress in 1963 have failed to materialize. Only in so understanding can subsequent steps be taken to develop more effective systems in the community.

NAMI is grateful to Senators Moynihan and Danforth for having the compassion, wisdom, and courage to introduce this very important legislation. We are further grateful to the members of the Committee for having provided us with the opportunity to testify about this bill. We are committed to advocating for its passage in both Houses of Congress and stand ready to work with your Committee in any way we can to facilitate this process. Thank you for your interest and attention.

PREPARED STATEMENT OF SENATOR DONALD W. RIEGLE, JR.

Good Morning and thank you all for coming to this important hearing. Today, the Subcommittee will explore the problems of homeless people who need mental health care services and discuss possible solutions. S.62, a bill introduced by Senators Moynihan and Danforth, is one such solution intended to address the needs of this very vulnerable population. We have a very distinguished list of witnesses including, experts in the field, providers, government officials, and a formerly homeless person. We are also fortunate to have one witness from my home state of Michigan, Dr. Saul Cooper, who has had many years of experience in this area.

The problems of homeless people are very visible to each and every one of us. We see them every day, on the streets or near the subways and we cannot continue to ignore their problems. As many as three-quarters of a million persons are homeless on a given night and between 1.3 million and 2 million persons may be homeless at some point during the year. Countless others may be teetering near the brink of homelessness—one missed paycheck or personal crisis away. And it's a disgrace to this country that children are the fastest growing group among the homeless population. Over one-third of the homeless are families with children; 100,000 children may be homeless on any given night.

In Michigan, as many as 90,000 people are homeless. Some shelter providers say the rate of increase is as much as 50% for women and children. There are over 170 shelters in my state, with about 4600 beds. They have on many occasions been operating at or above capacity especially during the colder part of our Michigan winters. Yet, as recently reported, the Census data indicates only 4,046 homeless in the state of Michigan. The Census Bureau acknowledges that the figures are not a complete representation of the homelessness in America. That is why I think we need to send a strong message to those who might seek to use such figures that we do not and will not accept these figures as being an accurate count of the homeless.

This country has a dramatic housing problem and the most acute result of the shortage of affordable housing and the increased rent burden on families' resources are the growing number of homeless persons and families in communities across the country. And the current recession leaves many more families at risk of homelessness. We need solutions to this problem.

As Chairman of the Senate Committee on Banking, Housing and Urban Affairs in the 101st Congress, I helped to design the National Affordable Housing Act which also reauthorized the Stewart B. McKinney Act programs for the homeless. This Act also created the Shelter Plus Care Program designed to provide rental assistance and supportive services to homeless persons who are seriously mentally ill, have chronic problems with alcohol or drugs, have AIDS or a related disease. This week, I offered an amendment to the 1991 Budget Resolution, that was accepted, to dedicate almost $1 billion in new funding for low income housing. If there are more dollars available for low income housing, there will be fewer homeless people. I will also soon re-introduce the Homeless Outreach Act of 1991. This bill would require the Social Security Administration to reach out to homeless people in soup kitchens, shelters and day centers to teach them about the benefits for which they may be eligible. And it is my hope that Senator Moynihan's Subcommittee will hold a hearing on this bill as well.

In August of 1989, I formed a special Task Force on Homelessness in Michigan to help evaluate how effectively we are addressing the issue of homelessness through our governmental programs. The Task Force works with communities throughout the State of Michigan, including all types of interest groups, on issues relating to homelessness and affordable housing. A hearing on this topic that I held in Detroit had close to 500 in attendance. I believe this shows us that the level of public concern is high.

The hearing today focuses on the specific problems of mentally ill people. Mentally ill persons make up a substantial percentage of the homeless population, ranging from 20 to 40 percent. These people suffer from such serious mental illnesses as schizophrenia, manic-depressive illness or severe depression. In Michigan, a 1988 study of Detroit shelters indicated that 25% of the people served had a history of prior psychiatric hospitalization and one-third had prior treatment for alcoholism.

S. 62 would require states to establish mobile outreach teams in metropolitan areas to identify homeless mentally ill people and help them obtain needed services. It also would provide for assessment and referral centers where homeless mentally ill people could get help and would establish a national commission for the homeless mentally ill. This effort would assist those already on the front line trying to help, such as Community Mental Health Centers and other programs under the McKinney Homeless Act such as Health Care for the Homeless Clinics, by coordinating the existing available services and preventing the fragmentation of services that is typical for this population. We will hear today about several projects that have been successful.

In many communities, obtaining health care can be a daunting experience, even for people not burdened by homelessness. The problem is even greater for homeless people who are displaced from their neighborhoods. And most of these people have not a penny of health insurance.

More than ever before, this country needs a national program to provide health care coverage to all Americans. Together with my colleagues in this Committee and the Labor Committee, I will soon introduce legislation to provide affordable health care for all Americans and to control rising health care costs. This Subcommittee intends to hold more hearings this year and move a bill forward as much as we can.

I applaud my colleagues, Senators Moynihan and Danforth, for stepping forward with a plan and look forward to working with them on their bill. To help mentally ill homeless people, services such as outreach, assessment and counseling and linkage to more programs is urgently needed.

PREPARED STATEMENT OF OLIVER SACKS

A grave problem has developed in the care of the mentally ill—so that now, as never before, large numbers of psychotic patients, dangerous to themselves and others, are wandering, without care, homeless on our streets. Perhaps 25 to 40 percent of the homeless have severe psychiatric illness. We all agree that something must be done—that there need to be outreach teams, outpatient centers, assessment and referral centers, large numbers of adequate (and adequately supervised) residences; and, not least, good (and economically run) psychiatric hospitals when these are needed. Of the 100,000 or so mentally ill patients in New York State, roughly a quarter need chronic hospitalization, another quarter recurrent hospitalization. My own experience, as a neurologist, has been especially with the state hospitals, and my testimony will chiefly concern these.

I was a consulting neurologist at Bronx Psychiatric Center, a state hospital (alias Bronx State), from 1966 to 1991, when I was laid off. In my 25 years there I have seen a great deterioration in the level of patient care, and in the morale of the whole hospital. The hospital attracted physicians and others of excellent quality up to the mid-seventies—some of them with national reputations—but then became less and less able to do so, partly because of failure to provide competitive salaries, and partly because of failure to maintain essential services. Bronx State has declined until it has become a third-rate institution—and this has generally been the fate of state hospitals throughout the country in the past twenty years.

In February, New York State laid off some 1280 physicians, therapists and nurses; further lay-offs are impending. These lay-offs are bringing the already marginal levels of medical and psychiatric care in state hospitals to critical proportions. Let me give you an example. Many patients at Bronx State have medical or surgical or physical problems besides their psychiatric ones. The hospital used to have excellent rehab facilities—physiotherapy, speech therapy, etc., and a fulltime physiatrist. Late last year I was asked to see a young woman. Her chart said, "Difficulty moving arm: rule out neurological disease." This woman had broken her arm a month before, and had had the upper arm bone pinned. But, with the closing of the physical therapy department, and the firing of the physiatrist, she had not got the physical therapy she needed—and her shoulder was now severely "frozen." With proper treatment, and daily physical therapy, no such freezing would have occurred. This freezing will be difficult to reverse: she will be somewhat disabled for the rest of her life. This is entirely a consequence of reduced staff, reduced facilities, and inadequate care.

Bronx State has steadily lost all its services—not only physical therapy, but its lab, its EEG department, its x-ray department, everything. It is losing all its specialist clinics—the eye clinic, the orthopedic clinic, the neurology clinic, everything. Patients now have to be sent out—for everything—not only at great inconvenience and with much stress, but at enormous cost. The "savings" in cutting and abolishing these on-the-spot services will be more than offset by the cost of these services outside—unless, of course, the patients are given no services at all, as happened with the young woman who got a frozen arm.

Let me return to the central question of care. Care is not a commodity (as in the ludicrous Medicare phrase, "health-care provider"), but a relationship. Consistency and stability of patient-therapist relationship is all-important, especially for psychiatrically-ill patients whose worlds are so in need of such support. Something which has been highly deleterious since the mid-seventies has been breakdown in the continuity of care, and its fragmentation in many different ways. Patients need to have a doctor or therapist—the same doctor or therapist—whether they are inpatients or outpatients. The single most important factor in patients' lives—one at least equal to all the tranquilizers in the world—is this consistency of human relationship and care.

To give you an example of the dangers, and costs, of fragmenting care: I have known a young patient, with severe neurological as well as psychiatric problems, since 1976, and have seen him regularly throughout this time. He has had four "psychotic breaks" or "psychiatric decompensations," so-called, *each one triggered by the loss of a therapist* (twice by the avoidable transfer of his therapist, so that he or she is no longer "on the case"). When he decompensates and becomes grossly psychotic, he must be readmitted to hospital, and may have to spend up to six months there. The cost of this hospitalization is perhaps $30,000—but there is also the cost of atrocious and avoidable psychic torment. When I was laid off from Bronx State, I feared for him—I knew he would come apart again if I, who had known him so long, left. So I have arranged to continue seeing him—informally, unofficially, and without payment. I wish I could do this with all my patients. For it is not just the loss of medical care which is so serious at this time, but the loss of supportive and therapeutic *relations*. There has already, in the two months which have elapsed since the lay-offs in February, been a great increase at Bronx State in psychotic symptoms, as well as a great increase of untreated or inadequately treated physical problems of all sorts.

The hospitals, then, are in bad shape—the worst they have ever been. And added to the problems already mentioned is one of chaos and headlessness caused by having increasingly huge bureaucracies of medically-unqualified people who never visit the wards, never see patients, and have no idea of the realities of illness or care. "Administering" hospitals as if they were factories has become universal now; wards and patients and staff change continuously; and what has been lost is the centrality of care, the sense of therapeutic relationship and care, and the sense of community which used to exist, and was so healing in itself.

The vast deinstitutionalization set in motion in the early sixties was based on the belief that tranquilizers would transform the lives of patients and the natural history of mental illness, and the belief that there would be good outpatient facilities and crisis centers, and the belief that the community would be welcoming and supportive.

All three of these beliefs, unhappily, have proved false. Tranquilizers tend to have a dulling effect, and have a significant risk (perhaps 10%) of inducing neurological disorders (tardive dyskinesia, for example). Tranquilizers, therefore, are not always welcomed by patients; many refuse to take them. Even when they are taken, they do not alter the course of mental illness. Communities, especially large metropolitan communities, are themselves too chaotic, too internally divided, to provide a haven for anyone, least of all highly disturbed patients.

But, most seriously, there has been a massive breakdown in outpatient services—Bronx State had five outpatient clinics, including a crisis center and outreach team; now it has a single, very inadequate outpatient clinic on its grounds, and no capacity for dealing with crises or outreach. The single most important crisis center in San Francisco closed down last month. Thus, with the latest wave of state cutbacks, not only will there be a great "release" of sick patients to the outside—but the outside will be less able than ever to cope with them.

The term "crisis" may be too mild for the effects we will see of this combined breakdown in inpatient and outpatient services—and it is a matter of the utmost urgency to provide funds, and, as important, *intelligence* to offset a catastrophe. I applaud what will be done outside the hospitals—but it is equally crucial to look inside them as well, and to find ways of restoring the level of medical and psychiatric care, and morale and coherence, they so need.

PREPARED STATEMENT OF RICHARD C. SURLES

New York State, like other states with large urban centers, continues to experience the phenomenon of homelessness even in the face of multiple efforts by the State, New York City and other local governments. Clearly, one of the most visible groups among the homeless are persons who are mentally ill. Under the personal leadership of Governor Mario Cuomo, New York has expanded its commitment to address the special needs of the mentally ill. This effort has resulted in vastly increased community services targeted specifically to the homeless, including mobile outreach, 24 hour emergency services, acute inpatient services in general hospitals and specialized treatment units in state hospitals. Implementation of intensive case management for the homeless mentally ill and aggressive efforts to develop specialized housing with supports are well underway.

Despite these efforts, we continue to struggle with problems that evade easy solutions. The public's response to encounters with homeless persons is often one of outrage and many attribute the existence of homelessness to the failure of government policies in mental health.

We still remain uncertain as to the precise magnitude of the problem. Several studies in New York have attempted to count homeless persons and identify components of this heterogenous population. The number of individuals who are homeless in New York is believed to exceed 48,000. This population includes an average of 12,000 single adults who use the public and private shelters nightly as well as 20,000 adults and children in facilities serving homeless families. Furthermore, there are thought to be as many as 16,000 single adults and an unknown number of families who are unsheltered on any given night. Ninety two percent of the state's homeless population is believed to be in New York City and its northern suburbs.

It is estimated that one in four homeless persons has a serious mental illness. Studies done by New York State Psychiatric Institute have shown that approximately 24% of single homeless adults using the shelter system have a diagnosis of serious mental illness. Less is known about the prevalence of serious mental illness among other parts of the homeless population. Several studies composed of small samples suggest that the prevalence of serious mental illness may be somewhat higher among the street population.

The scope and causes of homelessness in New York State, and in New York City in particular, are complex. While seriously mentally ill people are highly represented among the homeless single adults, homelessness was not created by a failure of mental health policies alone. Issues of inadequate income, absence of affordable housing, and a lack of access to appropriate health, mental health and social services are also causes of homelessness, however there is a tendency to combine these issues with deinstitutionalization in state psychiatric hospitals.

At its height in 1955, the census in the New York State psychiatric hospital system was 93,000. The largest reduction occurred between 1965 and 1976, when the census declined from 81,000 to 30,000. The largest portion of this decline resulted from deaths of very elderly patients and the fact that after 1965 most people admitted to the hospitals were discharged back to the community once they were no longer in need of psychiatric treatment.

Deinstitutionalization resulted from a combination of factors. Availability of effective medications which had been in use since the mid-1950's began to permit many people to recover from the most debilitating aspects of their illness and national mental health policy supported a belief that people with a serious mental illness could be better served in the community. In addition, litigation in the 1970's shifted decision making for involuntary hospitalization from doctors to judges.

The advent of the Medicare/Medicaid program in the mid 1960's also proved to be very influential. The passage of the Medicaid Act provided access to nursing homes throughout the country for low income persons and reduced pressure on the state hospitals to be the primary provider of long term care for frail and disabled elderly persons—leading to a decreased demand for long term state hospital care. Supplemental Security Income for the disabled also provided financial support for many who could leave institutions.

While the census of state hospitals continued to decline from 1976 to 1987, the dramatic reductions which had occurred in earlier years leveled off. During the late 1970s and 1980s, admissions remained relatively stable at approximately 24,000 a year.

While the federal Community Mental Health Act of 1963 attempted to establish a national system of community care, it failed to address issues of linkage for those being discharged from state hospitals and for the provision of other than clinical treatment services. Expansion of community mental health centers did provide a point of reference for leadership in community mental health, but the number of centers and the services that centers could provide were never sufficient nor intended to meet the income and support requirements of those that became homeless.

Twenty five years after the enactment of the CMHC Act, I continue to believe that many of the philosophies and principles that shaped the development of community based services were sound. The major failure was the inability to anticipate the range of services and supports necessary for people with mental illness to live successfully in the community.

During the 1960's and early 1970's, many people leaving state institutions moved into inexpensive Single Room Occupancy residences (SRO's), residential hotels or adult homes. While the conditions in these settings were frequently marginal, they afforded privacy and safety to people living on a limited fixed income. Some received regular visits by caseworkers. By the mid 1970's, rising real estate values in urban areas like New York City resulted in the destruction of the SRO market, dislocating many poor people, among them people with mental illness.

As the SRO's disappeared, the former residents, many with mental disabilities, became permanently homeless. By the 1980's this population became increasingly more visible on the streets of most large urban centers.

New York has developed a substantial network of community residences, but the demand far outstripped availability. Furthermore, for many of the mentally ill among the homeless, the structured, congregate nature of these residences proved unacceptable. Likewise, the characteristics and needs of homeless persons who were mentally ill often represented a challenge for providers who were accustomed to more compliant patients coming from long term institutional settings.

While a policy of community care has been in effect for many years in New York, public debate continues as to why many of the mentally ill among the homeless are not in hospitals. In fact, many are intermittently hospitalized in the municipal, voluntary and state hospital system. However, for many, mental illness is not a constantly disabling condition and it is legally impossible, even if it were desirable, to hospitalize someone indefinitely for an illness which manifests itself periodically.

Since 1987, the adult state hospital census in New York has once more begun to decline at an accelerated rate, decreasing from 20,000 to 13,600 today (Chart 1). We believe that this recent census decline is due primarily to the implementation of new community treatment strategies for those most at risk. For the first time in a decade, annual admissions in 1990 to New York State adult psychiatric hospitals have also decreased from approximately 24,000 to 19,000. Despite this dramatic decline, expenditures and utilization of State inpatient care in New York remains twice the national average.

The increased role of community hospitals in providing acute inpatient psychiatric care has had a significant impact on decreasing the demand for state inpatient care. The State's policy to encourage community hospitals to be the primary provider of both emergency and acute care allows people to receive short term treatment in their home community and ensures that they will receive a level of medical evaluation which state hospitals are ill equipped to provide.

In 1960 there were 2,100 acute psychiatric beds in community hospitals statewide. Today there are 5,200 beds in 102 hospitals which admit over 70,000 persons each year. Community hospitals are now the largest providers of acute inpatient care in the State (Chart 2). In addition, beginning in 1987, any community hospital operating an inpatient psychiatric unit must be licensed to admit patients who meet emergency involuntary commitment standards or receive a specific waiver from this requirement.

There are many people who have not been well served by the current system. For some, efforts must be improved to ensure that they receive adequate access to inpatient hospital care. Success in appropriately utilizing inpatient settings is largely dependent upon the availability of community alternatives so that those currently in hospitals who no longer require inpatient care can return to the community with adequate supports. We have already found in New York that reliance upon inpatient beds without community support for those ready to return to the community merely gridlocks emergency and inpatient services.

The traditional community mental health approach was developed with an assumption that clients were motivated to access treatment and would comply with treatment plans. The reimbursement structure of most state and federal funding mechanisms is built upon a methodology which provides a payment for a unit of service occurring during a scheduled office visit. In order for a program to remain fiscally viable, it needs to serve patients who can be depended upon to keep appointments. This is not a service system designed to serve people who may deny their illness, fail to keep appointments and are fearful of mental health professionals.

Most community mental health agencies are still struggling to adjust to a new generation of younger clients who combine serious and multiple problems such as homelessness and substance abuse with mental illness (Chart 3). It is only within the last several years that new strategies which tailor services for the mentally ill among the homeless have been successfully employed.

Many of the new strategies designed for the mentally ill among the homeless draw upon traditional treatment approaches, while others require the development of new techniques and organization of services. We now know that service strategies must emphasize outreach and engagement and provide access to emergency services which have low demand reception centers as well as day programs and affordable housing. While there are some outstanding examples of component parts of these new strategies in a number of cities, there are few systems which have sufficient capacity to respond to the level of need and diversity of those who require care and treatment.

We are many years away from actually solving the complex problem of homelessness for those who are mentally ill, but elements of a solution are being successfully identified and implemented. After many years of negotiating between the City and the State, a series of New York/New York Agreements have been implemented which represent a concensus around the need for increased access to a range of services which cut across traditional state and local responsibilities. Governor Cuomo has highlighted these agreements in his annual State of the State message and has sponsored special events at the signing of the agreements to acknowledge his support.

The first of these agreements was developed in response to dangerous overcrowded conditions in the City hospitals operated by the Health and Hospital Corporation (HHC) during the late 1980's. Psychiatric emergency rooms and inpatient psychiatric units were continuously over capacity. For years, this longstanding problem had been addressed by routinely transferring patients directly from emergency rooms to upstate state hospitals—hospitals usually ill equipped to treat patients with multiple medical problems. The new agreement effectively defines the role of

HHC hospitals as the provider of acute care, increases the capacity of the state hospitals to provide intermediate and long term care, and utilizes state teams to assist the HHC hospitals in providing adequate discharge planning for those returning to the community. The agreement also expands the State's commitment to provide specialized inpatient care for the mentally ill among the homeless in state hospitals.

Since this agreement was signed in April, 1989, occupancy rates in the HHC hospitals have declined from a high of 102% to a manageable range in the mid 90%. Similarly, the number of people waiting in an emergency room for whom a bed is unavailable has been reduced from an average of 33 to 3 each day and the practice of direct transfers to state hospitals from emergency rooms has been halted (Charts 4 & 5). Of significant note is that the demand for transfer to state inpatient beds has been far less than anticipated.

A second New York/New York Agreement to House Homeless Mentally Ill Individuals was signed in August, 1990 by the Governor and Mayor Dinkins. Through this agreement, 5,225 homeless people with serious mental illness will be provided with housing by June 1993. State and City funding is provided to develop 3,314 units of affordable housing and the state will finance on and off-site supportive services.

The most recent New York/New York Agreement for Homeless Outreach in the Grand Central Terminal Area was signed in November 1990. The purpose of this agreement is to provide outreach, engagement and linkage for those homeless persons who frequent the public areas in and around the Grand Central Terminal. This agreement is permitting us to test a variety of outreach strategies. Services are targeted to that portion of the population who are persons believed to be mentally ill, chemical abusing or HIV positive. Through the creation of coordinated outreach teams, assessment and referral centers, reception centers, housing placement services and a range of specialized services, this most recent initiative is showing some success in relocating people from the terminal into appropriate treatment and housing.

Increasingly, public authorities, health care organizations and third party payors are developing approaches to services which insure that a defined population is guaranteed appropriate access to preventative, maintenance and treatment services. While this "managed care" approach has been emerging for some time in general health care, it is only recently that similar strategies have begun to emerge in mental health. The concept of targeting services to defined high risk or high need populations, providing linkages so that the enrolled individuals receive the appropriate type of services while creating a single point of responsibility underlies many of the service strategies that New York State is currently employing in mental health.

The Intensive Case Management Program is an example of an advocacy oriented managed care program serving a very disabled and disadvantaged group (Chart 6). The program emerged from Congressional action in 1985 which permitted states to add case management services to the Medicaid program if the state could assure that the expansion would be cost neutral. This program has enrolled approximately 5,000 high need, high risk individuals, many of them homeless, in what can be described as a social health maintenance organization. Specially trained case managers, working closely with clients, are responsible for arranging or purchasing necessary health, mental health, housing and support services. This program has demonstrated the feasibility of adopting a managed care approach to assure access to appropriate services for at-risk individuals while reducing overreliance on expensive emergency and inpatient care (Chart 7).

Beginning this year in New York, another form of managed care is being implemented through arrangements in which community mental health providers and the local mental health authority agree to guarantee access to outpatient mental health services for high priority populations. This program, known as the Comprehensive Outpatient Program, clearly fixes responsibility for coordination of inpatient, emergency and outpatient services with community mental health providers and requires that they engage in coordination of service provision that goes well beyond the traditional role of many community agencies. An increased payment is contingent upon the provider assuming such responsibility.

The "Homeless Mentally Ill Outreach Act of 1991" would play an important role in augmenting and supporting the roles of state and local governments in designing strategies which respond to the needs of the mentally ill among the homeless. Federal financial participation for service strategies such as mobile outreach for assessment and referral, would permit the implementation of even more aggressive efforts to transition the mentally ill homeless to treatment, support and rehabilitation services. In New York we have already found the outreach function to be essential in identifying and engaging known street people who have resisted services. The Act also recognizes the necessity for emergency response and support in transporting people requiring involuntary hospitalization.

In 1982, New York City, under the auspice of Health and Hospital Corporation, established a network of outreach teams for the mentally ill homeless known as Project HELP. Project HELP teams, staffed by mental health professionals, have the primary designation for transporting homeless mentally ill people, determined to be in need of involuntary hospitalization, to emergency rooms in municipal hospitals. While these teams were effective in transporting some people from the streets, the limited "police function" of the teams frequently resulted in an antagonistic relationship with other outreach teams and interventions were poorly integrated with other parts of the service system. It was not uncommon for psychiatric emergency rooms to disagree with the initial assessment of the outreach team, and to discharge the patient back to the street. When patients were admitted to the hospital, and did respond to treatment, they frequently remained for long periods in acute care settings due to few discharge options.

Since 1987, the role of Project HELP has been expanded and is now more integrated with other outreach teams and support services. Project HELP is also providing services to drop in centers and is linked to intensive case management, mental health services, temporary housing and medical treatment.

In addition to the outreach function performed by Project HELP, there are 6 other teams in New York City operated by community agencies which provide outreach services to homeless mentally ill persons living on the streets. Outreach services are funded almost entirely through state dollars. During the 1989/90 State fiscal year, New York spent $3.2 million on mobile outreach services to over 2,100 mentally ill homeless people living on the streets.

Experience with outreach teams suggest that they are most effective when comprised of mental health professionals rather than police. The specialized mental health training enables them to recognize the symptoms which would necessitate hospitalization. My personal experience has been that the police are trained to react to threatening behaviors in a manner different from mental health professionals. The most appropriate role for police may be to back up the outreach teams especially in neighborhoods in which the safety of the team could be an issue.

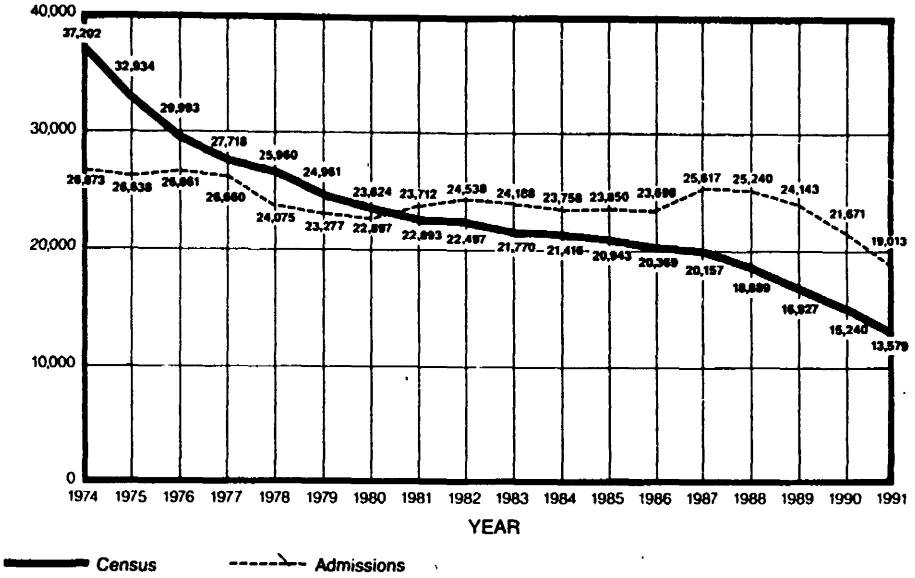
New York has several examples of assessment referral centers suggested by the Act and we support the flexibility established in the bill that would permit these centers to be either hospital based or free standing. Through surveys coordinated in psychiatric emergency rooms, we have found that homeless people frequently use emergency rooms for a variety of non-medical reasons. Many times a person may simply require a temporary place to sleep, obtain food, social supports or meet a variety of other non-medical needs. Through the New York/New York Grand Central Initiative, assessment and referral centers have been established in locations frequented by homeless people and a range of services are provided which respond to a variety of special needs populations.

The intent of the Act to create presumptive Medicaid eligibility for a limited period of time for those identified by outreach teams is a welcome direction. Project HELP estimates that approximately 70% of the street dwelling, mentally ill homeless population are eligible for but are not receiving benefits. Thus, these people are grossly underserved and remain in substantial need of a variety of services, making them more likely to remain homeless and an increased risk for physical violence and severe physical and mental illness. This is a critically important incentive which will address many barriers to service.

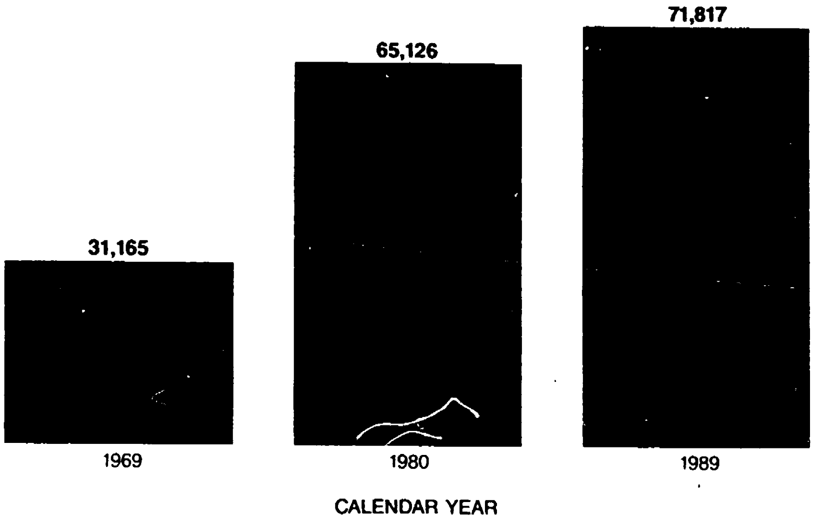
Over the past 25 years, we have seen dramatic changes in issues confronting the American public mental health system. Homeless persons with mental illness represent a very visible failure of many aspects of the current system. Rather than defend past practices, we need to acknowledge shortcomings and move to develop strategies which are more responsive to the mentally ill among the homeless. The Homeless Mentally Ill Outreach Act of 1991 provides a cogent framework for engaging this population in the service system. Accomplishing the goals of this act will require that federal, state, local government and community agencies support each other to develop approaches which adequately respond to the scope of this complex problem.

New York State

Inpatient Census and Admissions Trends in Adult Psychiatric Centers 1974-1991



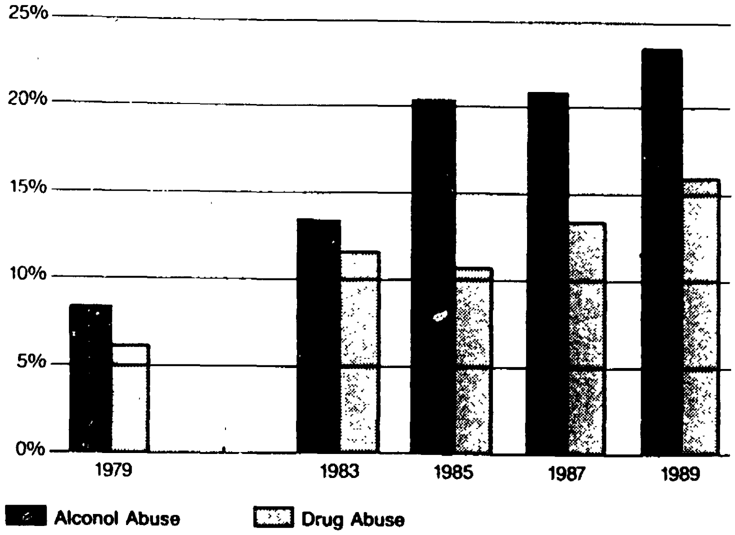
New York State
General Hospital Admissions with Psychiatric Diagnosis



Data 1969 - Statistical Yearbook
1980 - SPARCS Annual Report 1980
1989 - SPARCS Tape 1989

New York State

Proportion of State Hospital Inpatients with Alcohol and Drug Abuse: 1979 to 1989

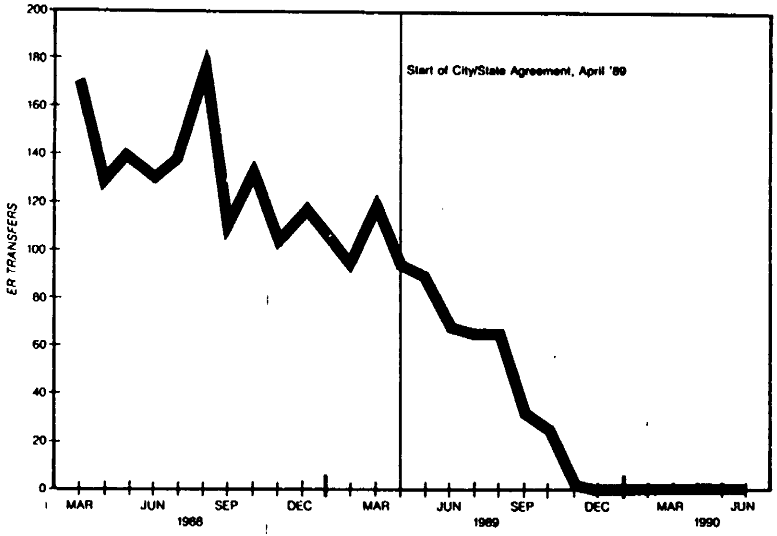


86% of drug abusers were alcohol abusers
58% of alcohol abusers were drug abusers
3/31/89

New York State

Psychiatric Emergency Room Transfers from Health and Hospitals Corp. Hospitals to State Psychiatric Centers

March 1988 to June 1990

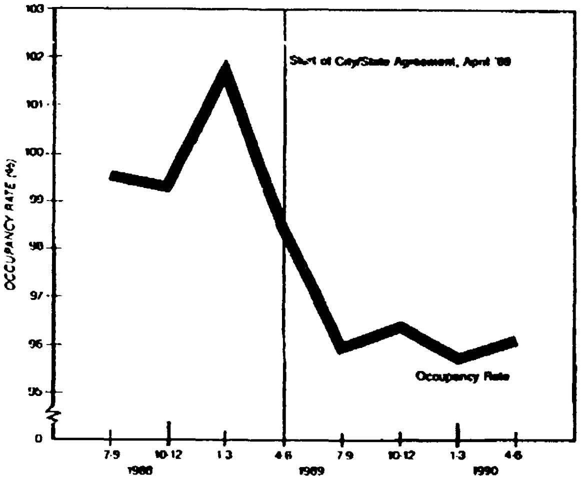


New York State

New York City Health and Hospitals Corp.

Occupancy Rates for Inpatient Psychiatric Services*

July 1988 to June 1990



* Occupancy rate refers to 1,500 psychiatric inpatient beds located in 11 Health and Hospitals Corp. Hospitals.

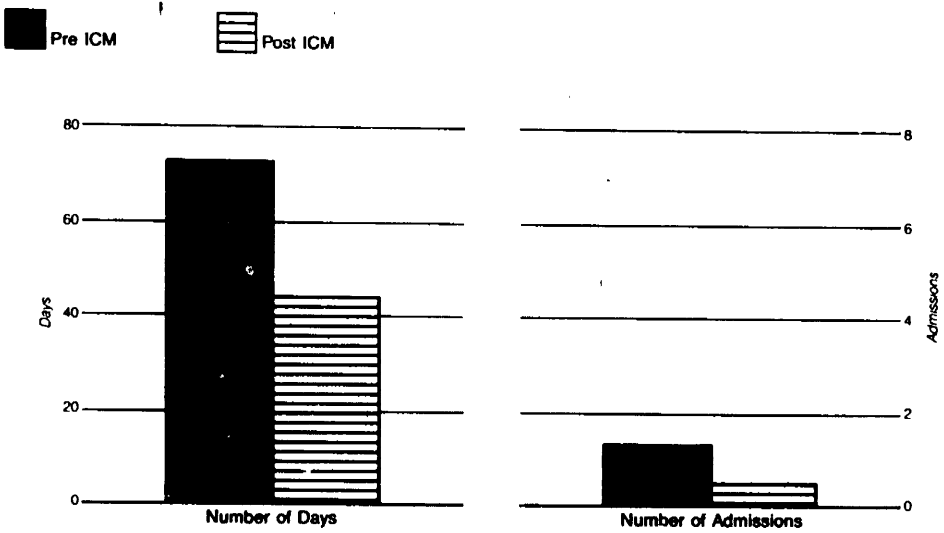
New York State

Intensive Case Management for Persons with Severe Mental Illness: Client Characteristics

- 60% male
- 80% under 45 years old
- 90% single
- 24% parents of children under 18
- 89% unemployed
- 72% covered by Medicaid
- 87% diagnosed with major mental illness
- 54% diagnosed as schizophrenic
- 50% secondary substance abuse diagnosis
- 99% previously hospitalized

New York State

Changes in State Hospital Inpatient Utilization Six Months Before and After Admission to an Intensive Case Management Program



Based on 1198 individuals from OMH 132 matching to DMHIS
BESR September, 1990

COMMUNICATIONS

STATEMENT OF THE NATIONAL COALITION FOR THE HOMELESS

Since 1982, the National Coalition for the Homeless has fought to end homelessness through public education, community organizing, litigation, and advocacy on a national level. NCH is the oldest and largest grassroots organization advocating on behalf of homeless Americans, with a board of directors from around the country.

This statement will first discuss current issues surrounding homelessness among persons with mental illness. It will then offer specific recommendations with regard to S. 62, "The Homeless Mentally Ill Outreach of 1991."

BACKGROUND

In every American city, and increasingly in suburban and rural towns, the sight of a disheveled person—clutching all his or her belongings and engaged in animated conversation with unseen companions—has become commonplace. Nearly half a century since the Housing Act of 1949 established the national goal of "a decent home and a suitable living environment for every American family;" and over thirty years since President Kennedy proposed that, with the establishment of community mental health centers, "reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability" [1]—here are more people with serious mental illness living on the streets and in shelters than there are in public mental hospitals.[2]

According to conservative estimates, often cited by the federal government, there are up to 600,000 homeless people in the U.S. on a given night, and at least one million over the course of a year.[3] While even aggressive efforts at fuller coverage fall short of an accurate count (as the Census Bureau admitted when it released the results of its 1990 S-night count), we believe the number (over the course of a year) to be in the millions. Numerous studies supported by the National Institute of Mental Health suggest that one third of the single homeless population has a severe and disabling mental illness.[4]

MYTHS AND REALITIES SURROUNDING HOMELESSNESS AND MENTAL ILLNESS

Those that subscribe to the "pathology" theory—that homelessness is the result of personal defects—tend to view mental illness as the prevailing, indeed definitive, frailty of "street people." Rather than examine the structural factors involved, proposed solutions to homelessness thus tend to focus on the disabilities of the individual and the need to "resocialize" the mentally ill so that they can live in stable housing.[5] Attention shifts exclusively to the incapacities of these prospective tenants and away from the scarcities of the housing market. Not surprisingly and all too easily, that theory slips from a recitation of the failure of deinstitutionalization of the mentally ill to a call for mass reinstitutionalization—involuntary if need be—as the keystone to any solution to homelessness.

This argument flows from the perception that homeless people who live on the streets do so by choice, demented or deranged though that choice may be; or have refused offers for shelter because they are mentally ill and are incapable of making rational decisions. While is true that mental illness impairs one's judgment, there are other equally important factors at work, and a host of research studies suggest that many people take up residence on the streets for good reasons.

Research has generally shown that roughly one-third of homeless people who sleep on the streets have a serious mental illness.[6] In some areas, probably due to the deterrent quality of shelter offered, the prevalence of mental illness among homeless street populations is believed to be slightly higher than among sheltered populations.[7] Like the general homeless population, those with mental illness often find the streets to be a safer, quieter place to sleep than dehumanizing, overcrowded, violence ridden shelters. Where shelters are filled to capacity and routinely turn people away, others don't have the luxury to choose. Actively psychotic persons are frequently denied shelter or are barred for failure to follow shelter rules. In Washington, D.C., 68% of homeless people who slept primarily on the streets during the winter months of 1988 had used or tried to get into a shelter during the past year; a study of New York City street dwellers yielded similar results.[8]

These and other myths surrounding homelessness and mental illness have been debunked by numerous studies. A recent report by the National Institute of Mental Health on deinstitutionalization and homelessness, which reviewed the current literature, supports what service providers who work with people with mental illness have been saying for years:

- Deinstitutionalization was not a primary cause of homelessness in general.
- Most severely mentally ill persons who were deinstitutionalized or never institutionalized are not homeless today.
- Very few homeless adults (5-7% in one study) need acute, inpatient psychiatric care.
- Homeless people with mental illness do not want or choose to be homeless.
- Most homeless people with mental illness are willing to accept assistance if it is offered in an appropriate, non-threatening manner.[9]

FACTORS CONTRIBUTING TO HOMELESSNESS

Disappearance of Cheap Housing

The lack of viable housing options is the fundamental cause of homelessness. Although mass deinstitutionalization began in the early 1970s, it was not until the 1980s that people with mental illness started to appear in large number on the streets. Some lived with family or in nursing or board-and-care homes. Others were able to find cheap rooms in Single Room Occupancy (SRO) hotels or other marginal housing. Fifty-five percent of patients discharged from a New York psychiatric hospital went on to live in SROs, according to a 1979 study.[10]

The gentrification and urban renewal that swept through America's skid rows in the 1980s—and which continues to this day—drove housing cost up and poor people out. Nationwide, between 1970 and 1982, over 1 million SRO units disappeared, nearly half of the total stock of housing especially receptive to discharged psychiatric patients.[11]

In the scramble among the poor for the diminishing stock of low income units that remained, it was the marginally employed, the physically disabled, and the mentally ill who were least able to compete for an increasingly scarce good. As the market got tighter, shelters started to overflow with the losers in housing game. Almost half of New York City shelter clients in a 1980 survey cited SROs and other cheap lodging houses as their previous residence.[12]

Inadequate Incomes

The dramatic decline in the availability of affordable housing seen in the 1980s coincided with rising poverty and shrinking incomes among the nation's poor. Between 1980 and 1990, the average after-tax income of the poorest fifth of households was projected to fall five percent, after adjusting for inflation.[13] In addition, substantially more Americans were living in poverty during the 1980s than at any time during the 1970s.[14]

Many people with persistent mental illness who are unable to work must rely on paltry federal Supplemental Security Income (SSI) benefits as their only source of income. Even when combined with Social Security and Food Stamps, annual SSI benefits for a single adult in 1990 equaled $5,318—only 86% of the federal poverty line.[15]

The Affordable Housing "Gap"

As a result of these two trends, the gap between the income of poor Americans and the cost of housing has increased dramatically over the past twenty years. In 1970, there was one "affordable" [16] unit for each poor renter household. Today, there are 8.5 million households that can afford a maximum monthly rent of $242, but only 4.3 million units currently exist with rents at or below that level—a gap of 4.2 million units. In other words, for every two renter households in the bottom quarter of the income distribution, there is only one unit renting at a level they can afford.[17] As a result, poor Americans living in unsubsidized housing typically spend fifty, sixty or even seventy percent of their income in rent, leaving them extremely vulnerable to homelessness; one serious illness or SSI check lost in the mail can spell disaster for someone with no cushion against eviction during an emergency.

In a recent study, NCH found that in 12 of the nation's 25 largest metropolitan areas, even if an SSI recipient spent his or her entire grant on housing, it would still not cover the cost of a one-bedroom unit at Fair Market Rent.[18] In the 13 remaining cities, after paying the average rent, the amount of money that a person would have to spend on all other needs ranges from $2.77 a day in Pittsburgh to just 7 cents in St. Louis.[19]

Federal housing assistance, though increasing, is woefully inadequate. Quadrupling the number of federally subsidized housing units over the last twenty years (from one million in 1970 to over four million in 1990) did virtually nothing to close the growing housing gap affecting poor Americans. Only 25% of Americans eligible for federal housing assistance currently receive it. In most cities, waiting lists for housing programs are years long, or are closed completely.

Of course, some homeless people need more than affordable housing to make the transition from the streets to a stable home. But no lasting solution to contemporary homelessness is possible without a recognition of, and a full set of programs designed to rectify, the severity of the current crisis in affordable housing.

For those homeless people with mental illness, the principle problem is not that they are categorically resistant to efforts to help them off the streets. Nor is it that we do not know what the solutions to their homelessness are. Rather, there is a serious lack of the kinds of resources homeless people with mental illness want and need: housing and the supports necessary to maintain that housing. Although federal officials frequently claim that we simply do not know enough about the complex problems of the homeless mentally ill to warrant increased commitment, it was almost one year ago that a federal agency came to this unambiguous conclusion:

> "The real precipitating causes of homelessness, even among the mentally ill, seem to be the lack of affordable housing, the persistence of poverty, the fragmentation of the social welfare system, and the breakdown in personal and social supports. Any solution to the problem of homelessness must address all of these causes in order to be effective."[20]

S. 62—THE HOMELESS MENTALLY ILL OUTREACH ACT OF 1991

The "Homeless Mentally Ill Outreach Act of 1991" proposed by Senators Daniel P. Moynihan and John Danforth represents an important step toward ensuring that homeless people with mental illness are no longer ignored and that they will receive federal benefits to which they are entitled. However, it does not, in our estimation, go far enough toward ensuring that, once given their due regard, they will be adequately provided for.

The Limitations of S. 62

While we commend the goal of S. 62 to provide much needed psychiatric services to homeless persons, access to mental health services alone will not end their homelessness. Before outlining our recommendations with regard to the Homeless Mentally Ill Outreach Act, I would like to emphasize the limitations of the Act.

A comprehensive response to the needs of disabled homeless people must also include a massive expansion of a range of housing options. If the goal of outreach is to end a person's homelessness, stable housing (and a level of income necessary to maintain it) must be made available. If it is not, outreach efforts will be meaningless. At best, they produce an endless holding pattern designed chiefly to accomplish with psychiatric means what the police are powerless to do—rid the streets of this spectacle of pain.

In addition to expanding homeless people's access to mental health, health and social services, we urge Congress to take the following actions:

1. **Establish an entitlement to a housing voucher or certificate for all citizens with incomes that prevent them from accessing decent affordable housing without a subsidy.**
2. **Raise Supplemental Security Income benefit levels above the poverty line.**
3. **Expand federal support for community-based mental health and support services.** Despite the steady shift of patients from state mental hospitals to the community, only 800 of the 2,500 community mental health centers which were to replace hospitals were established. To make matters worse, 30% reduction in federal support for community mental health services occurred between 1980 and 1988. With local fiscal crises deepening, such services are vulnerable to drastic cuts in cities across the country. In addition to clinic services, vocational rehabilitation programs

for people with mental disabilities must be expanded so that those who are able can obtain meaningful employment.

Recommended Improvements to S. 62

The National Coalition for the Homeless also makes the following recommendations with regard to S. 62, which we believe, based on years of experience working with homeless people with mental illness, will improve the ability of service providers to offer help to those who need it in a humane and comprehensive way.

1. **Emphasis should be on voluntary participation by homeless individuals.** Given that only a small minority of homeless people with mental illness require acute psychiatric services, and since S. 62 does not supersede state laws governing involuntary commitment, we object to the bill's provision requiring that homeless people be involuntary transported to assessment-referral centers. There is concern among some service providers and advocates that the language authorizing involuntary transport implicitly directs states to rid the streets of homeless people with mental illness as efficiently as possible, without regard to how this is done.

Successful intervention with homeless people with mental illness who may not respond to initial efforts to engage them in treatment requires establishing trust with an individual whom the system—and society in general—has merely cast aside.[21]

Outreach teams should not be given the authority or responsibility to involuntarily commit individuals who they believe meet the state's commitment criteria. In order to avoid severe damage to relations between outreach workers and clients, teams should instead be required to provide information about committable individuals to the proper authorities (i.e. police or clinical personnel).

2. **Services should be provided on-site, if necessary.** This frequently involves repeated encounters with the individual, with offers of blankets or a cup of coffee, on his or her "own turf," not only on the streets but at drop-in centers, where homeless people can obtain basic services, which have been shown to be an effective "front door" to linkage with on-going mental health services.

Common sense dictates, and federally sponsored research confirms, that homeless persons with mental illness place higher priority on meeting basic survival needs than on the receipt mental health services. Recognizing this, experienced outreach programs offer basic necessities, such as food, clothing, access to bathing facilities and shelter, on-site, (i.e. on the streets, in transportation terminal, etc.) before attempting to engage a person in formal mental health services.

3. **Outreach and engagement services should be performed by persons experienced in working with this population.** Many persons with mental illness who are homeless resist treatment because of bad prior experiences—such as undesirable side effects from medications or conflicts with mental health providers—that have left them extremely distrustful of the mental health system. Outreach workers must not only have experience in serving homeless people, but must be sensitive to their needs and concerns. We strongly object to employing law officers on outreach teams; successful outreach models have found the proper role of the police to be one of providing back up during potentially violent situations. States should be encouraged to include mental health consumers and persons who have experienced homelessness in teams.

4. **Services must not be time limited.** It can take several months or even years of contact with a resistant client for outreach workers to convince a treatment resistant person to come in off the streets, and even more time to engage him or her in a treatment regime. Therefore, the duration of outreach and engagement services must depend on the pace at which the client is willing or able to proceed. Placing rigid time limits on transitional services also assumes that housing and other services are abundant and readily available in the community, and that entitlements can be obtained within a 30-day period—both of which have proven rarely to be the case.

Presumptive eligibility for Medicaid should begin with the date on which the individual is first contacted by the outreach team and should extend until a final decision is made with regard to the individual's eligibility. During this period, individuals should also be eligible for all Medicaid covered services (including those not in the state plan), including case management, clinic services, and psychosocial rehabilitation.

5. **For purposes of outreach, a "unit of service" must be defined.** Medicaid reimbursement structure typically takes a fee-for-service form. However, in the case of street outreach, the demands of precise accounting do not square easily with those of effective engagement. It becomes very difficult in practice to define what—for purposes of street outreach—a reimbursable unit of service is. We recommend that careful consideration be given to as flexible a definition as possible of service units

for purposes of outreach and that the necessary paperwork be kept to an absolute minimum. The funding guidelines of the federal Community Support Program are instructive in this regard.

6. **Where feasible, facilities already accessed by people who are homeless and mentally ill should be designated as assessment and referral centers.** Emergency shelters, homeless health clinics, drop-in centers, soup kitchens and other places where homeless people feel comfortable and safe, and that may already be providing the required services to homeless people with mental illness, should be used as assessment and referral centers. The definition of "assessment and referral center" should also be expanded to include mobile soup kitchens and clinics. States must guarantee that each center is reasonably accessible in terms of the hours of operation and location.

7. **Emphasis on obtaining housing and income support should be equal to accessing psychiatric services.** Engagement in psychiatric treatment is certainly an important goal, and one which can be made attractive to a majority of homeless mentally ill folks. However, the process can, for some, take several years, and has proven to be particularly difficult in the absence of a safe and stable place to live, a place where one can direct one's attention away from survival towards issues of health. Furthermore, acceptance of psychiatric treatment as a precondition for receiving housing does not necessarily result in greater housing stability.

Research on programs that attempt to link homeless mentally ill people with housing and ongoing mental health services suggests that efforts to locate housing should begin early in the service process. Those which emphasized access to housing lead to higher rates of housing placements than more clinically-focused services. This approach was also found to be more closely matched with the goals of most clients, which appears to be an essential element of a successful housing placement.[22]

8. **Follow up services must be provided to ensure that treatment plans are fully implemented.** Too often, a well meaning plan is developed only to fall apart without proper monitoring or advocacy on the part of the person responsible for developing it.[23]

9. **Coordination with other services is essential.** Outreach teams and assessment centers must coordinate with mental health, housing and income maintenance agencies, as well as programs that currently provide outreach and other services to the population—homeless health clinics, shelters and grantees under the federal PATH program, for example. We recommend that, in each Metropolitan Statistical Area, an advisory council made up of public and/or non-profit agencies that provide direct and referral services be formed to foster coordination.

States should also be required to include the provision of outreach, assessment and referral services under this program in the State Mental Health Plans which are mandated by P.L. 99-660.

10. **Efforts must be made to facilitate the often grueling SSI application process.** Too often, homeless persons who are eligible for disability benefits are denied benefits or determinations are seriously delayed. In most states, since Medicaid benefits are contingent upon SSI eligibility, agreements between the Social Security Administration (SSA) and outreach programs should be made to ensure that homeless persons receive benefits to which they are entitled.

S. 62 should be amended by adding provisions of the "Homeless Outreach Act," sponsored by Senator Donald Riegle in the 101st Congress. Provisions include mandated expedited consideration of benefits for applicants who are homeless and a requirement that SA personnel train outreach and/or assessment staff on how to assist clients to enroll in SSI or make regular visits to the centers to assist in the application procedure.

The bill would also establish presumptive disability for homeless people with "obvious mental illness." Presumptive disability can serve as an effective means to encourage treatment resistant persons to seek treatment; after a few months of receiving a check, a person may agree to see a mental health professional, which is a requirement of the permanent eligibility determination procedure, in order to keep the checks coming, and to increase the likelihood of obtaining permanent housing.

Where feasible, assessment centers should also be certified to perform the medical or psychiatric evaluations required for SSI eligibility determinations.

11. **Participation by the states should be mandatory but states should be given discretion in determining the number and location of outreach teams and assessment centers.** Since the rate of homelessness varies from community to community, and since it is no longer just a "big city" problem, NCH recommends an alternative method to establishing outreach programs rather than according to Metropolitan Statistical Areas (MSAs). It is possible that some MSAs have not been shown to

need the services provided under S. 62. On the other hand, there are certainly non-metropolitan areas where the need for outreach services warrants establishment of a team. If an MSA within a state has not yet shown a need for outreach services, the state must simply appoint a team and designate a site to serve as an assessment center so that if such a need does arise, service providers may contact the designee. A formal and public announcement of the existence of the team must be made to all service providers within the MSA. States should also be required to designate outreach teams in non-metropolitan areas with a demonstrated need.

Basing the jurisdictional distribution of outreach programs on mental health catchment areas, rather than on MSAs, should also be considered.

12. States should be required to begin implementation of an outreach program immediately upon enactment of S. 62.

13. The program must be evaluated not later than eighteen months following enactment of S. 62. HHS should evaluate and report on the success of the program based in part on progress reports submitted from each state. At a minimum, reports must include number of persons contacted and engaged in services as well as service outcomes for each person, including number and types of housing placements. The HHS report should include recommendations for any necessary regulatory or legislative changes to the program.

14. A commission on homelessness and mental illness is not needed. A Task Force on Mental Illness and Homelessness has already been created within the Department of Health and Human Services with the goal of developing a federal plan of action on this issue. NCH supports this task force as well as ongoing research efforts of the National Institute of Mental Health. However, we believe that establishing a commission will only delay further federal action on a pressing issue for which viable solutions already exist.

ENDNOTES

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14. U.S. House of Representatives, Committee on Ways and Means, *Overview of Entitlement Programs: 1990 Green Book; Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means* (Washington, D.C.: U.S. Government Printing Office, 1990), 723.
15. U.S. House of Representatives, Committee on Ways and Means, 1022-1024.
16. Housing affordability is calculated according to standards adopted by the U.S. Department of Housing and Urban Development. Housing is considered affordable if rent consumes 30% or less of a household's adjusted monthly income.
17. Joan Alker and Cushing N. Dolbeare, *The Closing Door; Economic Causes of Homelessness* (Washington, D.C.: National Coalition for the Homeless, 1990), 4-5.

18. A Fair Market Rent is the cost (rent and utilities) of renting existing units that meet minimum quality standards, as determined by the U.S. Department of Housing and Urban Development.

19. Alker and Dolbeare, 17.

20. National Institute of Mental Health, 20.

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STATEMENT OF THE NATIONAL MENTAL HEALTH ASSOCIATION OF THE MENTAL HEALTH LAW PROJECT

The following statement is submitted to the Senate Committee on Finance by the National Mental Health Association and the Mental Health Law Project.

The National Mental Health Association is a voluntary health organization working for improved care and treatment of persons with mental illnesses, expanded research into the causes of mental health problems, the prevention of mental health problems and the promotion of mental health. NMHA is organized in 46 states, with over 600 affiliates.

The Mental Health Law Project is a 20-year old, national non-profit advocacy organization dedicated to protecting the rights and improving living conditions for people with mental disabilities.

HOMELESSNESS AMONG PERSONS WITH MENTAL ILLNESSES

Serious mental illness, in its various forms, is far more prevalent than most people realize; yet as a society we give little priority to mental health treatment and little support to those who have the disorders. On any given day, people with mental illnesses occupy more hospital beds than people with any other illness—more than cancer, heart disease, lung disease and diabetes combined. But also, on any given day, people with mental illnesses occupy more park benches than people with any other illness. This is a scandal, of our own making of which we should all be ashamed.

The severe cutbacks in creation of low income housing in the late 1970's and 1980's, the continuing reductions and restrictions in social support programs (including several years during which the Social Security Administrative systematically cut off disability benefits to large number of persons with mental illnesses), and deinstitutionalization without appropriate community services, has brought about the crisis we face today where approximately one-third of homeless people are believed to have a major mental illness.

The homeless mentally ill population has been described as a heterogeneous, multi-need and underserved population.[1] Research suggests that the homeless population (including the homeless population with mental illness) falls into three groups: those who are suffering from a situational crisis (who are not usually on the street, but have a crisis and lack shelter on a particular day), those who are episodically homeless (sometimes have a place to live, but are intermittently on the street for a short period of time, less than a month at a time), and those who can be classified as street people (who regularly live on the street, or are on the street for more than one month).[2] A study in Philadelphia found that of the homeless individuals who had a mental illness, one third could be classified as "episodic homeless," 43% were street people and 13% had a situational crisis.[3] in total, the homeless individuals with mental illness made up one-third of the total homeless population.

Of the three groups, the most difficult to serve are those classified as street people, particularly those who have been on the street for some time and seem to want only to be left alone.

EFFECTIVE INTERVENTIONS

For individuals who are traditionally non-help seeking, a process known as "engagement" is an effective intervention.[4] Through engagement the outreach worker or service provider attempts to reestablish basic trust in a system that has habitually failed the individual. The individual must be convinced that the services are offered on a voluntary basis, subject to his/her rejection at any time, and that they are available in settings that are acceptable to him/her.

Meeting the individual's most critical needs, as perceived by the individual, is a vital first step in engagement. it is not surprising that basic survival assistance—food, clothing, housing—followed by medical and dental care and financial assistance rank highest. it is not effective to offer psychiatric care to someone who has not eaten in 24 hours, or who is cold and wet and exhausted from lack of sleep.

On the other hand, this group has a need for significant mental health care. Older members of the group are frequently former state mental hospital patients; younger persons display symptoms of severe and persistent mental illness often with substance abuse as well. Once the basic trust and confidence have been established and the human survival needs met, the individual may be ready to accept and benefit from mental health services.

There are several successful programs which have utilized a combination of aggressive street outreach to identify persons with mental illnesses and appropriate services (developed at a variety of locations) to meet their varied needs. Philadelphia has operated such a program for a number of years, and recently New York City has initiated a similar plan. A voluntary outreach program also operates in Washington, D.C. in these programs, a combination of services is offered, including assistance in obtaining benefits, assistance in securing housing, mental health and substance abuse treatment, as well as immediate aid through the provision of food, clothing, crisis shelter, etc.

COMMENTS ON S. 62

S. 62 would build on the concepts of these successful programs, and provides an opportunity through the Medicaid program to reach this hard to serve population and provide both basic health services and mental health treatment. By utilizing the concept of assessment-referral centers, the bill establishes a mechanism for offering a range of medical and support services (including case management, which enables the program to offer the all-important service of assistance in accessing other benefits to which the individual may be entitled, such as income support and housing). Thus, in concept, S. 62 is built upon a firm foundation of experience and research regarding what works in assisting homeless persons with mental illness to move off the streets and back into a more normal lifestyle.

However, there are improvements which need to be made to the bill to make it fully effective in achieving its objectives and acceptable to groups advocating for people with mental illness.

First, S. 62 should not include a forced treatment component. As written, S. 62 permits an outreach team which could consist of one policeman (see page 6, lines 18-24 of the bill) to "involuntarily transport" a homeless person to an assessment-referral center "to the extent allowed under the state civil commitment laws.

The most sanguine interpretation of the provision is that it does no more than a state can already do. in which case, why have it. The more sinister view is that, by making the provision a requirement for the state to receive Federal Medicaid funds, its intent is to direct states to clear the streets of people whose erratic or bizarre behavior makes them appear committable. Under this bill, an individual with mental illness who simply refuses to go to an assessment-referral center may be forcibly detained for that reason alone.

We strongly object to this provision in S. 62. it may significantly undercut an individual's existing procedural rights under state law. it is not appropriate as a Medicaid-covered service, and the treatment elements of the bill would be rendered ineffective if outreach teams could also initiate commitment proceedings.

We urge revising the bill to eliminate the outreach team's authority to force anyone into treatment. No law enforcement authority is needed on the team. Each state has developed procedures for dealing with individuals who appear to be in need of emergency care. The outreach team should utilize these procedures.

It should be emphasized that individuals in need of involuntary treatment are a minority among the homeless mentally ill. Most persons with mental illness on the street do not require acute psychiatric services (research suggests that as few as 5-7% of homeless persons with mental illness require inpatient care), and there is probably an over-reliance on psychiatric emergency services at the current time because of the void left by inadequate residential and treatment alternatives.

Our proposed amendment does not violate the principles of S. 62, but would strengthen the effectiveness of the outreach team.

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clearly set up a new Medicaid service which states may use to provide both a period of presumptive eligibility to Medicaid services for this population *and* a set of new services provided through the assessment-referral centers. Since few individuals with these disorders are able to work on a sustained basis, a very high percentage of them are both disabled and have low incomes. Thus, Medicaid is an extremely important program for providing necessary health, mental health and related services for this population.

We recommend changes to the presumptive eligibility section of the bill to clearly state that homeless individuals identified by an outreach team worker as having a mental illness and in need of assistance become eligible on that day for all Medicaid services covered under the state plan. This eligibility should remain in effect until the day on which a determination is made with respect to the individual's Medicaid eligibility, or a maximum of 90 days for any individual who has failed to make a proper application for Medicaid.

Such a change would provide identified persons with at least 90 days of Medicaid coverage. During this time they would need to file an application with the appropriate agency to determine if they meet normal Medicaid-eligibility criteria (Social Security in the case of those who may be eligible for Supplemental Security income; the state Medicaid agency for others). This allows time for the outreach team to work with the individual and for the collection of the necessary medical and other evidence required to file an application for disability. Once the individual has applied for Medicaid coverage that the presumptive eligibility period should extend until the date on which a final decision is made on the application. To cut these people off from benefits simply because state and federal bureaucracies move slowly would be most unjust.

Once presumed eligible for Medicaid, the individual would be eligible for all services covered in the state's Medicaid plan. In addition, however, we urge that states have the option of adding to this package any other Medicaid authorized service (such as case management, clinic services or psychiatric rehabilitation) even if the service is not included in the state plan. This would enable states to target the most effective package of services, and greatly increase the chances of successful outcomes.

Third, we recommend amending the definition of the assessment-referral center and the listing of services it is authorized to provide. We would suggest that such centers be required to offer the following to eligible individuals:

(i) basic necessities, such as clothing, personal hygiene needs, food, blankets, access to bathing facilities, etc.
(ii) temporary room and board, and referral to appropriate transitional or permanent housing;
(iii) screening and treatment for medical conditions (other than psychiatric conditions);
(iv) psychiatric assessments, including assessments regarding alcoholism and drug abuse;
(v) mental health case management services (as defined under Title XIX)
(vi) emergency psychiatric intervention, if necessary;
(vii) assistance in applying for federal, state and local entitlements;
(viii) referrals to other needed services, including employment and job-training services, available in the community.

The assessment-referral center (which we believe might be better termed the assessment-referral-services center) should also develop an individualized treatment plan, in cooperation with the individual, for the provision of necessary mental health services, including specifically services authorized through Medicaid.

Another effective strategy for programs working to engage homeless persons with mental illnesses is to utilize consumer self-help programs. The assessment-referral centers should be required to include on its staff, either as paid workers or volunteers, individuals who have received mental health services, preferably individuals who have also experienced homelessness. Such a requirement will help to ensure successful outcomes. By being able to identify with the individual on the street, the consumer staff person may have less difficulty than others in making contact and assisting the individual in accepting services. increasingly, this approach is being used by mental health systems, and it is particularly effective with the hard-to-reach group of individuals with severe mental illnesses who are "street people."

To increase the effectiveness of the outreach team, we also suggest that they be authorized to provide services on-site for those individuals not yet ready to accept a referral to the assessment-referral center. This is an integral part of the engagement concept.

Fourth we are troubled by the definition in S. 62 of mobile outreach teams. The current language permits the "team" to consist of a single individual, who does not have to be a mental health professional. Such teams should be composed entirely of qualified and appropriately trained individuals. We would urge amending the bill to require that mobile outreach teams be composed of at least two people, both of whom have appropriate training and experience, and one of whom must be a qualified mental health professional.

In conclusion, we would like to strongly commend the subcommittee for taking a serious look at this problem, and in particular to commend and thank the sponsors of S. 62, Senator Moynihan and Senator Danforth for their leadership in addressing this very difficult and very serious problem.

Medicaid and SSI are the two most important resources for individuals with severe mental illness who are homeless. Unfortunately, they are to a large extent untapped resources because of institutional barriers. S. 62 would permit states to use the most effective approaches in meeting the needs of this population, and as such is long overdue. We know how to help, we know what to do, but we simply do not do it.

We urge the Finance Committee to make the changes we have suggested to the bill, and to act upon it swiftly. The thousands of homeless persons with mental illness are waiting on the streets for assistance, and before we realize it the winter of 1991-92 will be upon us. it would be gratifying to see this bill enacted in time for services to be available before more people suffer, and die, because we have turned our backs.

ENDNOTES

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3. The Mentally Ill Among the Homeless, Presentation at Conference on Homelessness: New Directions and Action Initiatives, presented by Richard C. Surles, Ph.D., Commissioner, New York State Office of Mental Health, December 1987.
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STATEMENT OF PROJECT REACHOUT, GODDARD RIVERSIDE COMMUNITY CENTER

One needs to look no further than the streets, parks, transit terminals and other public gathering places throughout our country to witness the failures of the well-intentioned policy of deinstitutionalization and our current system of care for the mentally ill.

In the interests of time, we will not here restate the history which brings us to this phase of human tragedy but rather refer you to previous testimonies on the subject. As a provider of outreach and case management services in a program which has been around for twelve years, we are heartened that mobile outreach is being recognized as a needed component of care for the mentally ill. while it is a sad comment that public places have become the repository for tens of thousands of people with serious and persistent illnesses, outreach programs which comb the streets have proven to be the most effective means of engaging and linking these people to services and moving them indoors.

COMMENTS ON S. 62

Mobile outreach, as described in S. 62, with its assessment and referral component, is the only means to begin to provide much needed care and treatment for the homeless mentally ill. For this reason we wholeheartedly support the intention of S. 62 but strongly oppose the provision of Medicaid as the form of funding for this service.

A. Funding

It is our contention that a restrictive funding stream, such as Medicaid, will impose obstacles that will render the essential components of the bill—outreach, assessment and referral—impossible.

Given that Medicaid is based on a fee for service construct, Medicaid will most certainly end up defining the service to be provided. As a funding source it lacks the flexibility and creativity needed for outreach and engagement to homeless people with mental illness. Reimbursement regulations will determine the frequency of contacts allowable and the length of time for each contact. Skilled outreach workers know that they need to be consistent in showing up *every day,* and depending on the individual, for just a few minutes or possibly up to an *hour* or *more.*

This form of funding will medicalize a service that does not need to be medical and may result in the overprofessionalization of outreach—and therefore be more costly to provide. This service can be provided by both trained laymen and (non-medical) professionals so long as they are sufficiently trained on issues of mental illness, substance abuse, homelessness and outreach and engagement techniques. We have found that practical, hands-on experience combined with other types of training are the best methods for learning the particulars of this population. Supervision by professionals experienced in the treatment of chronic mental illness becomes the essential ingredient for timely interventions of additional services.

Regardless of whether presumptive eligibility is established on the day the outreach begins and that person then becomes eligible for all Medicaid services covered under the state plan, it is doomed to failure if a *time frame* is imposed on the provision of service. Experience and research reveal that the outreach phase takes far longer than presumptive eligibility would allow for. while a very small number of those living on the street respond to offers of help the first day, the majority take much longer to engage, ranging from several months to several years. Reimbursement restrictions during this period would result in a bureaucratic nightmare; often it's difficult to learn the person's name, birth date or SS# or they are resistant to releasing information so that an application can be made on their behalf before the eligibility period is over.

Initial outreach interventions should be non-clinical and non-medical in nature and free of time restrictions. Essential services should be provided on site in a non-threatening environment such as an office, drop-in center, small shelter or meal program type setting as opposed to a large institutional clinic or hospital based program. Outreach efforts will fail if sufficient time isn't permitted for successful engagement to occur, and these should be well underway before psychiatric treatment is introduced. Although assessment begins at the outreach phase, it is ongoing and an individual's readiness to accept treatment and additional services should be considered when developing individual treatment plans.

For further evidence of the obstacles presented by this form of funding I refer you to the 1988 report prepared by the House Committee on Government Operations entitled *From Back Wards To Back Streets: The Failure Of The Federal Government in Providing Services For the Mentally Ill.* This impressive document of the 100th Congress reveals how the "Medicaid and Medicare reimbursement policies promote inefficient, expensive and often inadequate care for the mentally ill." [1] This is largely due to severe limitations set by the reimbursement criteria and this problem has been underscored by officials and service providers from several states across the country.

Another report, compiled by the New York State Senate Committee on Mental Hygiene and Addiction Control,[2] cites examples of "meaningful legislation" (state level) "intended to provide incentives to expand local mental hygiene services" being "thwarted by an executive decision based on financial concerns." A definition of mental disability was drafted without regard to clinical or programmatic judgments resulting in the exclusion of the very population it was intended to serve.

At present, Medicaid is plagued with skyrocketing costs threatening to bankrupt the entire system. It seems most foolhearted to introduce such a critical piece of legislation tied to a funding stream already on the verge of collapse. For these reasons we urge you to select another form of funding for this timely and courageous piece of legislation. The Community Support Program (CSP) funding stream is best suited for S. 62. CSP, initiated in 1977, was "designed to encourage a comprehensive approach to providing all needed community services to the mentally ill to include job training, housing and social services in addition to mental health services." [3]

Programs fortunate enough to have this type of funding have proven to be some of the most outstanding in the country, providing innovative and effective designs for servicing and housing homeless people with severe mental illness. In New York City, Community Support Services (CSS) funds have been responsible for such unique service models as the St. Francis Residence I, II, and III—on-site rehabilitation services; The Heights—on-site services provided by Columbia University Community Services (CUCS); Project Reachout sponsored by Goddard Riverside Community Center; Midtown Outreach sponsored by Manhattan Bowery Corporation; and Project Help sponsored by Gouverneur Hospital—model outreach programs, to name just a few. Many other excellent examples of CSS-funded programs are spread throughout the country.

B. Involuntary Transport and Commitment

The role of involuntary transports should belong to a specific designee of the local Commissioner of Mental Health authorized to act on his/her behalf in accordance with local civil commitment standards.

That function should remain totally separate and distinct from the overall outreach, assessment and referral effort. Only a small percentage of homeless people with mental illness suffer from psychiatric symptoms for which they require enforced hospitalization. Law enforcement officers may be needed at the time of involuntary commitment and transportation, but their presence on an outreach team would jeopardize the outreach effort and obviate the goal of establishing trust with homeless people.

C. Change in the System

Many health care professionals and institutions are reluctant to treat persons with chronic mental illness. The long term effectiveness of this initiative is wholly dependent upon substantial changes which must occur within the existing health and mental health systems of care. Traditional forms of treatment must be relinquished in favor of more effective continuum of care models. We know that outreach works. We know that with sensitive and skilled approaches people who have been living in the streets for five, ten, fifteen and even twenty years, suffering from delusions, disordered thoughts, paranoid ideations, isolated from family and friends, are capable of establishing trusting relationships. They will respond positively to offers of help and accept services so long as they can maintain what is important to them: their dignity.

As people move from the streets through the assessment and referral centers, they will again fall to life on the streets if appropriate housing and support services are not available to them. These people have suffered from our neglect for far too long. We know what to do, how to do it and the time to act is now.

ENDNOTES

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2. New York State Senate Committee on Mental Hygiene and Addiction Control, Senator Frank Padavan, Chairman: *The Mentally Ill Homeless: Shelters Become Sanctuaries for the Victims of Neglect* (January 1985), p.8.
3. See *From Back Wards To Back Streets* . . . (Etc.), *Supra*, p. 6.

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