# HOMELESSNESS

# AND

# PERSONS WITH MENTAL ILLNESS

submitted in accordance with L.D. 668 to the

Joint Standing Committee on Human Resources
and
Joint Standing Committee on Appropriations and Financial Affairs
Maine State Legislature

Maine Department of Mental Health and Mental Retardation
February 1992

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# HOMELESSNESS AND PERSONS WITH MENTAL ILLNESS

Homelessness has been receiving increasing attention as growing numbers of individuals and families find themselves on the streets and in the shelters of our communities in Maine and across the country. In these difficult times of severe economic stress and growing State budget deficits, responding to large-scale homelessness presents an unusually complex challenge. Many people feel they are not responsible for, can do little or nothing about, or cannot cope with the problems of homelessness. In fact, the impact of this awareness of homelessness and the individuals affected by it, as well as of the societal failure implicit in their homelessness, can lead some to diminish, reject, or deny the problem.

Placing responsibility on individuals for causing their own problems or for directly solving those of others cannot succeed in resolving what has become recognized as a public need and a public responsibility. This document proposes to begin identifying that public need in Maine and begin responding to that public responsibility for persons who have mental illness and are homeless.

## BACKGROUND

### L.D. 668, Resolve, to Direct the Department of Mental Health and Mental Retardation to Develop a Plan to Provide Appropriate Services for Severely Mentally Ill Persons Who Are Living in Homeless Shelters

L.D. 668, approved in May 1991, directed the Maine Department of Mental Health and Mental Retardation to develop a plan for homeless persons with mental illness. This plan, with its recommendations to be submitted to the Maine State Legislature by January 15, 1992, had to incorporate the following:

1. Establishment of a planning group composed equally of consumers of mental health services, family members of consumers, and mental health service providers.

2. Consultation throughout with the Maine Coalition for the Homeless and the Interagency Task Force on Homelessness and Housing Opportunities.

3. Plan for the provision of appropriate services, including residential alternatives.

On November 5, 1991, the Mental Health Committee of the Maine Coalition for the Homeless met in Bangor to identify the needs of persons who are homeless and have

mental illness, describe the status of the current system, and develop recommendations to forward to the Department of Mental Health and Mental Retardation in response to L.D. 668.

As a result of the Bangor meeting and in an effort to broaden participation, a statewide teleconference was held on December 20th using the Interactive Television System of the University of Maine - Augusta. Four interactive sites -- Presque Isle, Orono, Augusta, and Portland -- brought together interested individuals from all over the state to identify needs and develop recommendations. Robert W. Glover, Commissioner of the Department of Mental Health and Mental Retardation, opened the teleconference, and Margaret Marshall of the Interagency Task Force on Homelessness and Housing Opportunities; Don Gean, State Representative and Executive Director of York County Shelter, Inc.; and Joel Rekas, Executive Director of the Maine Coalition for the Homeless provided direction.

Mr. Rekas, as moderator of the teleconference, emphasized the challenging process ahead, noting that this statewide meeting represented only the beginning. The initial draft plan growing out of this teleconference was submitted to the Legislature in January and was distributed throughout the state for suggestions and amendment. This resulting plan is being submitted to the Legislature in late February.

The initial priorities identified by the four sites, which each included broad geographic representation, are identified in the "Needs and Priorities section of this document. These groups will meet again, not only on a local basis, but statewide on an ongoing basis to maintain a current, responsive plan and strategies for its implementation.

L.D. 668 Planning Group

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| Consumer Representatives: | Ray Bouyea, Lewiston<br>Ronald Rambjora, Bangor |
| Family Member Representatives: | Mary Lou Curtis, Bath<br>Cindy Melanson, East Holden |
| Provider Representatives: | Susan Brainerd<br>Greater Bangor Area Shelter |
| | Jon Bradley<br>Bridge, Ingraham Volunteers, Portland |

Consultation Representatives: Joel Rekas
Maine Coalition for the Homeless

Jane Fowler, Interagency Task Force on
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## HOMELESSNESS - ADULTS WITH MENTAL ILLNESS

### Numbers and Causes of Homelessness:

While studies present a wide range in the numbers of homeless individuals in our country who have mental illness--depending on the definition of homelessness used and the scientific rigor of the specific study, most estimate that approximately one-third of homeless persons have a mental illness.

In Maine, readjustments of 1985 homelessness figures estimated that on any given day there are about 350-450 persons who are truly homeless - or about 1,170 to 1,500 annually who have mental illness.[1] However, more recent data collected in a survey of homeless shelters in Maine indicates that this number has grown: from December 1, 1989 to June 30, 1990, at least 4,713 different persons were served in Maine shelters (one of the shelters reported only for the last two months).[2] Given this more recent number, the estimate of homeless persons with mental illness served in Maine's shelters annually would be more nearly 2,800. We know that this figure is probably higher, for these numbers for Maine do not, of course, include those persons who remain on the streets, in the parks, in jails or hospitals, doubled-up with others, the full range of those who move in and out of homelessness, etc.

Homelessness for these individuals has resulted from many factors:

- Changes in demography -- the absolute number of persons at risk of major mental illness has grown with the population, the percentage of elderly persons in Maine's population is increasing, growing numbers of single parent families, etc.

- Geographic mobility -- Extended family support and other natural and community support structures are weakened as people move more frequently.

- Stigma -- Myths and prejudices surrounding mental illness affect every aspect of the life of the person with mental illness, including the ability to obtain housing and employment.

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[1] To have a Home. Maine Task Force to Study Homelessness. Maine State Housing Authority: February 1985.

[2] ...by Sundown. Interagency Task Force on Homelessness and Housing Opportunities. Maine Department of Economic and Community Development: March 1991.

- Low income -- Many persons with severe and prolonged mental illness have low and, indeed, marginal incomes which may be from entitlement programs and/or minimum-wage or part-time jobs.

- Rising cost of housing -- The cost of housing has increased at a greater rate than the incomes of persons with serious mental illnesses. With the gentrification, urban renewal, greatly diminished low-cost government housing assistance, and increasing decay of housing stock, low-cost housing has been disappearing.

- Substance abuse -- A high percentage of persons with mental illness also abuse substances, increasing their likelihood of homelessness.

- Policy of deinstitutionalization -- Homelessness is not caused by the discharge of or failure to admit individuals to psychiatric in-patient institutions. It is caused by such factors as low income and a lack of appropriate community resources and supports.

- Lack of adequate and appropriate community resources -- The ability of persons with serious mental illness to maintain themselves in the community successfully is directly linked to the availability and accessibility of needed community-based services.

There is, however, no question that poverty and the lack of low-cost decent housing are the most pervasive causes of homelessness. And for the same reason, the numbers of people at risk of homelessness are even greater. It was estimated in 1985 that at least 52,000 households in Maine were at risk of homelessness, with the current number likely to be significant higher.[3]

Through its comprehensive local mental health planning process as well as other local housing/homelessness planning groups such as those in Portland and Lewiston/Auburn, the Bureau of Mental Health has identified five major areas of the State which contain the greatest concentrations of adults with mental illness who are homeless or at real risk of becoming homeless. Not surprisingly, these locations center primarily around the larger urban areas in Maine: Bangor, Augusta, Lewiston/Auburn, Portland, and Saco-Biddeford. These regions account for close to three-fourths of the homeless shelter population in Maine, the high proportion reinforcing the existing tendency to slight the needs of rural areas.

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[3] To Have a Home.

Characteristics:

The 1989-90 Maine homelessness shelter survey indicates that the shelter population is about four-fifths adult with only one-tenth aged 60 years and older. The median age is 30 years, the same as shown in other national studies. About one-half had a high school education or higher. Somewhat over one-third reported a monthly income, with an average of $475/month, with one-third of these from jobs and the balance from programs such as SSI, SSDI, VA, City welfare, and AFDC. Although the average length of stay was 27 days, 34% of those served in the shelters stayed only one night.[4]

Studies in other areas of the country have shown that mentally ill persons among the homeless population tend to have poorer family and other natural support networks, are more likely to become involved with the criminal justice system, are in poorer health, and were homeless longer. In addition, a high percentage of these individuals also have co-occurring substance abuse disorders.

While, clearly, most adults with mental health problems are able to work, a substantial number of those with severe and prolonged mental illness receive marginal incomes from Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI). It is estimated that there are a considerable number of additional adults with severe mental illness who also have incomes below the poverty line. Such individuals generally work at unskilled, entry-level positions. Many have no income at all - some of these are young adults not involved with the service systems or those who are unable to establish their eligibility for the federal entitlement programs.

While we do not have income information on all mental health clients, some data is available. About 55% of persons seen at community mental health centers and other community agencies receiving BMH funding have household incomes below $5,000 per year. Another 23% have incomes below $10,000. Since this represents a variety of mental health problems and a range of functioning, it can be assumed that the percentage of individuals with severe and disabling mental illness with low incomes will be even higher than the 78% reflected here.

In addition, it is being increasingly acknowledged that the rate of substance abuse among persons with serious mental illness is high and must be reflected in the services and programs developed. The percentages cited in Maine (by institutions, homelessness programs, residential programs, etc.) range from 50% to 90%. In addition to the planned development of specialized services for persons with both mental illness and substance abuse, existing programs in Maine are augmenting their services and staff training with substance abuse components.

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[4] ...by Sundown.

Homelessness Services:

Affordable, available, and appropriate housing has been identified as one of the top priorities of Maine citizens served by the Department of Mental Health and Mental Retardation. This is especially true of some of the more vulnerable population groups served by this department, a substantial number of whom have barely subsistence level incomes. Encompassing adults and children with mental illness and mental retardation, serious emotional disorders, and developmental disabilities, the housing needs of these special population groups are wide and varied, ranging from very structured and supportive to independent settings. Housing, with individualized supportive services provided as needed, is the essential foundation on which other programs are developed and a decent life in the community is built.

Apart from the regular Section 8 rental subsidies made available to low-income individuals, the network of supportive mental health residential programs established in Maine over the past few years represents a great deal of progress. Yet, even so, these programs do not meet the need.

A variety of mental health residential programs for adults with mental illness exist across the state from Madawaska to York County with more being developed. They range from residential services alone to supportive/subsidized apartment programs to intensive group settings. All these programs are generally quite small and have waiting lists. A growing number of these programs provide more independent, scattered-site living arrangements through the provision of community support services not tied to the site but to the individual. A unique, short-term (1-90 days) psychiatric residence in Portland provides specialized services to adults with mental illness who are homeless. This program provides a bridge for shelters, institutions, and transitional programs as well as other permanent situations.

The operating and supportive service costs for these programs are substantially State-funded, with Medicaid funding now available to some. However, all areas of the state, through local planning groups, consumer groups, other advisory and advocacy groups, and community agencies, still identify a continuing need for a variety of affordable housing options, residential services, and outreach services appropriate to the needs of this population.

At this point, the Bureau of Mental Health funds in part or whole, 231 beds/units through licensed agencies for persons with serious mental illness. The Bureau is funding operating/supportive service costs for 33 additional beds/units now being developed with the Maine State Housing Authority providing 1% demonstration housing loans: Cumberland County (South Portland); Kennebec County (Waterville); York County (Biddeford & Sanford); Penobscot County (Dover-Foxcroft).

In addition, a $12 million revolving State Mental Health Housing Fund -- seeded with a $4 million dollar bond referendum approved by Maine voters in November 1989 -- began with the development of 54 beds/units, nine projects which were RFP'd in York (Biddeford), Cumberland (Portland), Androscoggin (Auburn), Sagadahoc (Bath/ Brunswick), Kennebec (Augusta/Waterville), Knox (Rockland), Penobscot (Bangor area),Hancock (Bucksport), and Aroostook (Houlton) counties. This revolving fund provides low-interest loans but is dependent on the availability of other funds for related operating/ supportive service costs.

Mental health agencies in Maine continue to apply for the various housing funds available through the federal McKinney Homelessness Act. In the last Supportive Housing funding cycle, three Maine agencies were awarded McKinney funding: two for permanent housing projects and one for transitional. These applications required matching funds from both the Maine State Housing Authority and the Bureau of Mental Health.

In addition, beginning State Fiscal Year 1992, federal McKinney Act Projects for Assistance in Transition from Homelessness (PATH) Formula Grant funding in Maine for adults with mental illness who are homeless emphasizes outreach and case management activities focusing on shelters and the persons with mental illness they serve. These federally-funded PATH services at Motivational Services, Tri-County Mental Health Services, Counseling Services Inc., Community Health & Counseling Services, Shoreline Care, and Maine Coalition for the Homeless address concerns for firmer connections with shelters by dedicating case management time to shelters and establishing a training fund for shelters. Although the community support and psychiatric case management service programs throughout the state all work with persons who are homeless--or certainly at risk of becoming homeless, direct outreach and homelessness service provision through the shelters is critical to reaching those most in need and most vulnerable. Given the PATH funds available to Maine, this approach seems to provide the greatest impact by reaching more areas of the state and more people.

The three major objectives of the PATH programs are to identify and engage homeless individuals, to connect and engage those persons with services, and to establish them in stable housing. The PATH-funded services needed to accomplish these objectives include outreach, referral to other services (health, psychiatric, crisis, financial, vocational/rehabilitation, social, educational, etc.), and case management.

## HOMELESSNESS - CHILDREN WITH SERIOUS EMOTIONAL DISORDERS

### Numbers:

According to a 1987 survey conducted by the Maine Department of Corrections using Sheriffs and police departments as respondents, there were an estimated 2,000 children and youth in Maine who were either homeless or had a very high probability of becoming homeless.

A January 1989 Maine Department of Educational and Cultural Services survey of shelters in Maine found 2,935 homeless children between the ages of five and twenty in Maine during the 1987-88 academic year.

A February 1991 report, produced by the Portland Area Homeless Children's Mental Health Project (funded by an NIMH grant to DMHMR) and based on an analysis of case records for all children served during 1989 by Portland's three youth shelters (Youth Alternatives, YWCA Fair Harbor, The Lighthouse) and the YWCA Street Program, found of 614 children who were homeless in that area. This number was three times the number of homeless youth estimated by local officials in 1987.

A more recent survey of shelters for youth and families, as well as domestic violence centers, reported by the Department of Education and Cultural Services, indicates that there were 4,824 school-age children in Maine who were homeless in 1991. The largest percentage of these were of high school age: elementary (K-6) 640, middle/jr. high (7-9) 840, and high school (10-12) 3,344. The report estimates that approximately 64% of these children and adolescents were not attending school. The greater Portland area had 1,250, Lewiston/Auburn 475, Bangor 340, and Skowhegan 280 children who were homeless.

With recent and pending cuts in the State general fund budget and their impact on children's community programs funded by the four child-serving departments, the number of homeless children in Maine is bound to increase. The cuts in available community corrections and mental health services mean fewer services for increasing numbers of children, with associated increases in costly hospital admissions, street crime, and child abuse.

### Mental Health Characteristics:

Excepting limited resources pertaining to sexual abuse treatment, the mental health needs of homeless youth in Maine--and across the country--have traditionally been overlooked by youth-serving agencies. Research by the Portland Area Homeless

Children's Mental Health Project discovered high rates of mental health problems among homeless youth.

The frequency of mental health diagnoses included the following:

57% Substance Abuse Disorder
38% Post-traumatic Stress Disorder
27% Conduct Disorder
11% Attention Deficit Disorder
6% Affective Mood Disorders (depression, manic-depression)
4% Schizophrenia and other psychotic disorders

The complexity of mental health problems of these children is indicated by the fact that almost one-half (44%) of them had two or more diagnoses.

Other mental health characteristics included the following:

47% are suicidal (thoughts or threats)
43% had a prior history of mental health problems
16% had a prior psychiatric hospitalization.

Studies conducted elsewhere in the nation suggest that the actual rate of mental disorders and substance abuse among homeless and runaway youth in Portland may be much higher than reported in records that were available (only one of the four agencies serving these children, the YWCA, had a mental health license at the time of the survey). a recent study done on homeless street youth in Los Angeles, using a more rigorous psychiatric examination, revealed a rate of 26% for major depression and 34% for psychotic symptoms. This study found post-traumatic stress disorder at a rate of 38%, a figure identical to the Maine study.

## Services:

Maine was one of three states to receive funds for mental health services to homeless children under the Community Mental Health Services Demonstration grant program. The Portland Area Children's Mental Health Project provided mental health counseling, substance abuse counseling, and case management to homeless youth at a variety of sites in Portland. The project was specifically designed to establish close interagency collaboration and treatment coordination. The project board included members from City of Portland Dept. of Human Services; United Way of Greater Portland; We Who Care, a consumer advocacy organization; Cumberland County Child Abuse and Neglect Council; Portland Police; and a variety of other community agencies.

There are four Transitional Housing projects in Maine which provide treatment and other supportive services for residents. In addition, the Bureau of Children with Special Needs (BCSN) has several initiatives underway for networking among the staff of all these McKinney-funded agencies with meetings held between directors of the Transitional Housing projects.

With funding from the PATH Formula Grant, the Bureau of Children with Special Needs contracts for outreach case management and counseling services to children and adolescents who have severe emotional disturbance and who are homeless or at imminent risk of homelessness. Currently, four areas of the state are recipients of these funds: Bangor (Project Atrium), Rockland (Home Counselors), Lewiston (New Beginnings), and Alfred (York County Shelter). PATH Formula Grant funds are also used to provide training to these and other providers of services to this population. The objective of the PATH programs is that the child or adolescent remains at home, is returned home, or independent housing is found. In addition, it is an objective that the child remain in school or be returned to school.

Particularly difficult, however, are those instances where homeless children and adolescents are not in shelters and not with their families, especially those who are not anywhere long enough to involve in services or schooling.

## SUBSTANCE ABUSE SERVICES

With the increasing awareness of the high rate of co-occurrence of mental illness and substance abuse -- especially among those who are homeless or at risk of homelessness, a growing emphasis is being placed on the integration of mental health and substance abuse planning, funding, training, and services throughout the state and among programs and systems.

In addition to the Maine Office of Substance Abuse, the Department of Mental Health and Mental Retardation has established a distinct Office of Substance Abuse which provides for substance abuse services to individuals served by the department: adults with mental illness, youth with special needs (including serious emotional disorders), and persons with mental retardation. Its budget of over $1,000,000 is totally State dollars and provides for a wide variety of programs and services throughout the state, including those for persons who are homeless or at risk homelessness:

. Early intervention and prevention programs, all awarded and monitored by the Bureau of Children with Special Needs, for youth at risk of substance abuse and mental health problems: home-based care services for those at risk of being

removed or leaving their homes, parent support groups for families struggling to maintain relationships with troubled adolescents, and teenage peer support groups.

. Two projects in the two State mental health institutes offer substance abuse assessments of individual patients and technical assistance to mental health staff. Individual and groups counseling is also available on a limited basis. Expansion has been planned to add a clinical staff person with specialized experience and credentials in both mental health and substance abuse who would supervise the two projects and to increase the number of project staff to provide individual, group, and family therapy.

. Two community agencies provide mental health services to their area county jails. These services for persons with mental health and substance abuse problems who are in jail or in danger of being in jail include alternative sentencing programs, in-jail individual, group, and family counseling, training, and community support care.

. A small program for specialized, integrated services for residents with both mental illness and substance abuse problems in an emergency shelter in the southernmost county in Maine. (This shelter's data reflects that in the last fiscal year, 48.66% of its residents had substance abuse problems, 10.34% had mental illness, and 19.54% had both mental illness and substance abuse.)

. Two Bangor-based substance abuse treatment agencies, representing halfway house residences, extended care, and community detoxification programs, share the consulting services of a psychiatrist in order to respond more adequately to the needs of individuals with both mental illness and substance abuse disorders.

. Funding for various community programs increasingly stresses the integration and consolidation of mental health and substance abuse planning, funding, and resource development. This is seen as vital to meeting the needs of this most vulnerable population group which is so highly represented within the homeless population group.

The DMHMR Office of Substance Abuse has funded programs for both treatment and psycho-educational initiatives for persons with mental illness and substance abuse and has provided training for service providers throughout the state. The Office provides consultation to local mental health agencies in their development, use, and provision of substance abuse services. This coordination and collaboration also occurs on a local level among community programs with varying missions and expertise.

The Bureau of Mental Health and DMHMR Office of Substance Abuse have developed standard contractual language, effective FY 1992, for BMH-funded agencies

and organizations regarding the provision of services to persons with both mental illness and substance abuse. Related staff training expectations are also specified:

> No individual may be denied access to services solely on the basis of having a substance use/abuse disorder in addition to their mental illness. Provider shall develop and maintain a written protocol or policy which describes its service approach to individuals with co-occurring mental illness and substance abuse disorders. In addition, Provider shall ensure that appropriate staff receive training in the inter-relationship of mental illness and substance abuse as well as in the referral and treatment process.

In addition to the work of DMHMR's Office of Substance Abuse, current systemwide and statewide DMHMR Human Resource Development (HRD) initiatives in the development of post-secondary curricula for mental health personnel, especially the Mental Health Rehabilitation Technician positions, include substance abuse components. There is also a more specialized Substance Abuse Rehabilitation Technician I curriculum available as a part of this HRD project for persons in the mental health field. These specialized training tracks are an integral part of DMHMR mental health certification requirements which are to be in full effect by FY'95.

Community agencies working with persons with mental illness and substance use and abuse disorders who are also homeless or at risk of homelessness are increasingly employing and supporting staff who are cross-trained and can offer services appropriate to their programming on-site. It is becoming more common for agencies/programs to employ mental health staff who are also, for example, licensed substance abuse specialists (or vise versa). This expectation is especially clear for agencies funded for services for homeless persons with mental illness and substance abuse.

## STRATEGIES

The experience of the Department with the homelessness block and formula grant-funded agencies evidences coordination, along with outreach, as an essential intrinsic characteristic of services for persons who are homeless. These relationships are numerous, complex, and intertwined, and requires the development and use of a network of helping agencies.

The P.L. 99-660 Comprehensive Mental Health Plan for adults with severe and prolonged mental illness and children and adolescents with serious emotional disorders, in its identification of the highest priorities in the state, cited the need for "a broad, increased range of residential alternatives including long-term options and those directed toward specialized complex needs." This priority included affordable housing in general, a variety of specialized mental health residential programs, youth residential alternatives, and specialized options for persons with both mental illness and substance abuse. It was acknowledged that while housing alone may not meet the needs of persons who are homeless or at risk of homelessness, without adequate housing other efforts become moot.

The P.L. 99-660 adult mental health service regional planning groups identified a variety of housing and residential service needs by area, as well as the need for case management services which have an outreach capacity. These expressed needs in the P.L. 99-660 plan regarding housing and homelessness have been an integral part of the resource development in housing and homelessness efforts. Although considerable progress in residential and homelessness resource development has been made in the last three years, the bulk of the work remains to be done. The advent of the McKinney Supportive Housing programs and the Maine Mental Health Housing Fund (available for both youth and adult programs) have played a major role in this development.

The adult mental health services outreach/linkage emphasis has its roots in the 1988 fiscal year when a substantial growth in community support services took place, especially with the initiation of the intensive case management programs throughout the state. The homelessness grant program relies heavily on the structure and continued growth of these case management programs to provide the necessary context, linkages, and ongoing stability for these outreach efforts. Mental health services continue to be needed in shelters to provide mental illness expertise and experience toward the overall goal of assisting homeless individuals with housing, with permanent housing specifically, and with the residential services to assist them in maintaining that stable community tenure.

In addition to the internal collaboration of the Department's Office of Substance Abuse and the Bureau of Mental Health, the Office of Substance Abuse has funded programs for both psychoeducational and treatment initiatives for persons with mental

illness and substance abuse and has provided training for service providers throughout the state. The Bureau and Office are working on the development of standard contractual language for BMH-funded agencies/organizations regarding the provision of services to persons with both mental illness and substance abuse as well as related staff training expectations. The Office provides consultation to local mental health agencies in their development, use, and provision of substance abuse services. This coordination and collaboration also occurs on a local level among community programs with varying missions and expertise.

In addition, current far-reaching statewide HRD initiatives in the development of post-secondary curricula for mental health service personnel, including case managers and residential workers, include substance abuse components.

Maine's P.L. 99-660 Comprehensive Mental Health Service Plan for Children and Adolescents Who Have Severe Emotional Disturbance contains targeted objectives for case management, information and referral, and outreach, with special focus on homelessness. It is anticipated that during the coming year the four outreach case management positions will be coordinated with Maine's to-be-established case management system for children with serious emotional disorders.

Development of the four PATH youth outreach case management programs has been coordinated with Office of Substance Abuse Services in the Department of Mental Health and Mental Retardation. Training for the "McKinney outreach workers" includes a strong focus on substance abuse co-morbidity with other mental health diagnoses. All four agencies are agencies cognizant of the substance abuse co-morbidity issues. Research by Maine's McKinney Mental Health Services Demonstration project in Portland has documented and disseminated information about the substance abuse characteristics of homeless youth in Maine. The Maine Department of Mental Health and Mental Retardation in collaboration with State substance abuse agencies is planning a year-long series of training events on dual diagnosis clinical issues for all McKinney funded agencies in Maine.

## DATA COLLECTION

Bureau of Mental Health adult data systems are being developed for all other housing/homelessness efforts. A basic contractual demographic instrument has been drafted and is being developed to meet federal requirements.

For the Bureau of Children with Special Needs, homelessness data collected will have similar elements to data gathered for other child mental health contract agencies performing case management, information and referral, and treatment services. As each contracted agency is unique in its service array, each has distinct definitions of case opening and case closure. However, as Maine establishes a child mental health case management system, a greater uniformity to these definitions and to data collection efforts will emerge.

All these efforts for both the youth and adult mental health information systems are being developed in relation to two major initiatives in Maine: The departmental Maine Mental Health Data System Improvement Project (MHSIP) currently in its third year of federal funding and the massive information system requirements imposed by the Consent Decree resulting from the class action lawsuit filed by Augusta Mental Health Institute patients. The first provides the structure for the second. These are major efforts and encompass all mental health information system development within the department.

## PRIORITY NEEDS

In the December 20th statewide teleconference, each of the four local sites identified needs they considered to be the greatest in their areas. These priorities are listed and discussed in the order of the frequency with which they were identified. That is, those identified by all four regions are listed first, those given by three follow, and so on. The areas reporting the need are identified. The priorities as listed by area are contained in the Appendices.

### AFFORDABLE, ADEQUATE, APPROPRIATE, AND SAFE HOUSING OF ALL TYPES WITH APPROPRIATE SERVICES AVAILABLE. (Presque Isle, Bangor, Augusta, Portland)

All four sites identified the need for a full spectrum of housing options with supportive services. Bangor particularly noted the need for transitional housing and shelter with supportive services, as well as adult foster care homes.

With the impending military base closing, Presque Isle recommended the request of 20% of the current base housing be allotted to Presque Isle and Caribou to be used for supportive apartments and Single Room Occupancy units, with accompanying Section 8 subsidies. Presque Isle participants also identified the need for a housing advocate for clients and for landlords, who could provide education and information regarding persons with mental illness and mental health programs. It was stressed that landlords would have to be assured that there are programs and workers whom they could call on for support as needed for tenants with mental illness.

While identifying the need for housing options from independent subsidized apartments to structured homes, Portland participants were careful to point out that often there is a special population whose needs are omitted: homeless individuals with mental illness who are on the streets and who may--for a variety of reasons--have difficulty engaging with services. Often they require a place which affords them adequate space--distance and privacy from others and few, if any, demands or pressures for service or interpersonal involvement, while at the same time providing security and support. Many options involve too much isolation, too many people in small spaces, or too much service engagement.

While noting that care must be exercised that emergency services do not become long-term solutions, Augusta's participants noted the need for shelter capacity for persons with mental illness. They also stressed the very obvious and large gap in development of adequate housing options and residential services in rural areas, forcing individuals to leave their communities in search of services available in the more urban areas of the state.

REPRESENTATIVE PAYEESHIPS. (Presque Isle, Bangor, Augusta, Portland)

The need for "official" payees, who can manage the finances and checks, for some consumers of mental health services was cited as a priority by three of the locations, with the Augusta meeting agreeing that it was a need. While the federal entitlement programs allow for the designation of such a representative payee, the pool of individuals willing and able to accept the responsibility is small compared to the need. Some agencies, such as the Amity Center have established small payee programs. However, in addition to the greater numbers needed, concerns regarding the accountability and expertise are also expressed because representative payees, even where procedures are rigorous, are established and put in place without court intervention. Conservators or Guardians are appointed by the Court for individual determined to be legally incapacitated.

DEVELOPMENT OF A UNIFORM, AFFORDABLE, AND ACCESSIBLE MENTAL HEALTH SERVICE SYSTEM THROUGHOUT THE STATE. (Augusta, Portland)

Many of the priorities presented by the four sites identified missing or inadequate aspects of a comprehensive mental health service system. For this reason, they are grouped together here within this larger statewide system priority.

Increased Outreach and Case Management Services. (Bangor, Portland)

The intensive case management programs established throughout the state, with small client to worker ratios and outreach capacities, are already developing waiting lists. As has been noted elsewhere, case management services are particularly critical in the effective provision of coordinated services to persons who are homeless. It is not surprising that two of Maine's larger urban areas, with their concentrations of homeless persons, identify this as a major need.

Full Range of Crisis Stabilization Services. (Presque Isle, Bangor)

At the Bangor site, participants identified the need for a comprehensive range of crisis services, including a full twenty-four hour/day, seven-day/week outreach crisis stabilization program. At this time, this large service area contains only one small crisis program in Ellsworth with a 30-mile radius, different from most service areas where the larger concentrated urban areas have the programs and rural areas do not. The regional crisis hotline, Phone Help, it was said, could not begin to meet the need.

The urgent need for psychiatric respite beds and crisis stabilization beds, with supportive services and staff, were cited in both the Presque Isle and Bangor meetings.

Increased and enhanced counseling, psychiatric services. (Bangor, Portland)

The availability of skilled mental health professionals, especially those with specialized areas of expertise, continues to be problematic, although significant steps (establishment of the HRD training/certification Project and UMO and UNE Schools of Social Work) have been taken which should result in major systemic improvements. This gap was first identified in FY'88 as the most important statewide mental health need. Psychiatric services for these population groups, however, continue to be very difficult to obtain.

Development of daytime activity, service, and program alternatives. (Bangor)

Homeless persons with mental illness need to have daytime activities and services which are accessible to them. This is especially true for weekends, particularly Sundays, and holidays, when most agencies are closed.

Special Services for Special Populations. (Portland)

The needs of homeless persons with mental illness who also have substance abuse problems present a unique and difficult challenge requiring cross-trained professionals and well-coordinated, integrated services.

## DEVELOPMENT OF A COORDINATED COMPREHENSIVE MENTAL HEALTH SERVICE SYSTEM.

Establishment of a single point of application, referral, and coordination of service and entitlement programs within each service area. (Bangor, Augusta)

Given the range and complex nature of the needs of persons who are both homeless and mentally ill, the typical process where individuals must go from agency to agency, make appointments, be placed on waiting lists, be

referred back, etc., is daunting and defeating. It often sets up obstacles rather than simplifying and assisting the individual. The one-stop location for these purposes for various programs, which often are closely related, would be an alternative to explore, especially as government agencies are being restructured.

Coordination of Services for clients, not for the system. (Portland)

Services must be coordinated for the ultimate benefit of the individuals being served, not for the benefit of the system and its agencies and organizations.

Assurance that no one will be discharged from a psychiatric institution without adequate and appropriate supportive community services already arranged. (Bangor)

Homelessness can result when persons are discharged without discharge plans or to shelters or inadequate living arrangements. However, additionally, it can result when discharge plans are made but are inadequate or inappropriate to the needs of the individual. This latter is all too likely to occur when these needed community services are not in place or are not available and the individual no longer requires hospitalization.

INCREASED AND MORE FLEXIBLE TRANSPORTATION. (Presque Isle, Portland)

Adequate transportation, also identified as one of the top ten statewide mental health needs with the start of the comprehensive planning effort in FY'88, continues to be a very difficult problem everywhere, especially for the less urban and rural parts of the state. Even where public transportation exists, it is frequently limited and often not available evenings and weekends. Because of the expense involved, this has generally been seen as an intractable problem, which some mental health programs have attempted to alleviate to some degree by purchasing and using vans. Although of value, this program-specific alternative does not offer individuals flexibility or wide use. Integration and stability in Maine's communities is reliant on mobility -- to go to work (especially during off-hours and weekends), to shop, to socialize, etc. Further, without transportation, persons in rural areas are not able to take advantage of services that are available, so that often the only choice is to move to urban areas to access services. The availability of transportation affects all individuals, services, and systems.

DEVELOPMENT OF SPECIALIZED SERVICES FOR HOMELESS YOUTH WITH SERIOUS EMOTIONAL DISORDERS. (Augusta, Portland)

Services for homeless youth with serious emotional disorders are particularly inadequate, and almost non-existent, throughout the state. This special population is composed essentially of two major groups: First, those who are seventeen and under (who are very underserved) and second, those who are eighteen to twenty-one and often fit in neither adolescent nor adult services and programs.

INCREASED MENTAL HEALTH EDUCATION/TRAINING TO PERSONS PROVIDING SERVICES TO HOMELESS INDIVIDUALS WITH MENTAL ILLNESS. (Presque Isle, Augusta)

Presque Isle participants presented a need (which has been expressed by others throughout the state in other forums) for greatly increased mental health consultation and training for shelter staff who are frequently called on to deal with a wide variety and range of situations and needs with little or no training. Portland pointed out that a greater role is needed for consumers in teaching agencies and programs about the nature and needs of persons with mental illness who are also homeless.

PROVISION OF ADEQUATE MEDICAL CARE. (Portland)

Homeless individuals frequently have complex medical needs and, typically, have had no or poor medical care. Adequate health care, as housing, is a cornerstone in any effective intervention and stabilization.

PROVISION OF ADEQUATE INCOME FOR BASIC NEEDS.

Without the means to provide for basic needs, grave consequences, including homelessness, for the individual can almost be assured. This includes minimum wage, day care costs, health care costs, housing, and related costs. Income may include not only wages/salaries but also income from entitlement programs, subsidies, insurance, etc.

DESIGNATION OF PERSONS WHO ARE HOMELESS AND HAVE MENTAL ILLNESS AS A DMHMR PRIORITY POPULATION. (Augusta)

Designation of homeless persons with mental illness as a priority population for the Department of Mental Health and Mental Retardation will have significant impact. While this population has been designated as a "special" population group, its designation as

a priority population, along with adults with severe and prolonged mental illness, those persons unable to pay, and children and adolescents with serious emotional disorders, can affect funding and service delivery.

DEVELOPMENT OF AN ONGOING LOCAL COMMUNITY TASK FORCE TO ASSESS NEEDS, RESOURCES, AND SERVICES. (Presque Isle)

While there have been several small assessments, there has been no comprehensive, uniform survey identifying the needs of both individuals and the system or the resources available, especially from a coordinating, planning perspective.

## RECOMMENDATIONS

The following recommendations reflect the priority areas identified in the statewide teleconference, comments received in response to the January 1992 initial draft plan, and the meeting of the planning committee. They include recommended actions which involve changing perspectives and a wide range of additional financial resources.

**A CLEAR STATEMENT MUST BE MADE BY THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION THAT HOMELESS INDIVIDUALS WITH SERIOUS MENTAL ILLNESS, REGARDLESS OF AGE, ARE AN UNAMBIGUOUS PRIORITY FOR THE MENTAL HEALTH SERVICE SYSTEM.**

Special efforts are necessary to assure that homeless persons with mental illness receive and have access to needed services. This means, for example, that programs must emphasize outreach and followup. This designation must also acknowledge and incorporate the diversity of Maine's homeless population with mental illness and stress prevention and long-term strategies.

The awareness of the growing numbers of homeless persons with mental illness and their vulnerability was first recognized by the Department in its plan for 1985-86, which identified them as a special population among persons with mental illness. However, while planning regarding homelessness and persons with mental illness has been done primarily at the State level, future mental health planning efforts should also address the needs of this special population group, including youth and adults, at the local and regional planning levels.

A concern also has been voiced that not only the needs of homeless persons with mental illness must be considered but also the mental health needs of homeless persons in general.

RECOMMENDED ACTION: DMHMR policies and procedures will be made to reflect the designation of homeless persons with mental illness as a priority population, including contractual provision for the accessibility and appropriateness of DMHMR-funded mental health services to these individuals.

RECOMMENDED ACTION: DMHMR will reflect this priority designation in institutional discharge planning by reaffirming the unacceptability of discharge to shelters and other inadequate housing situations.

RECOMMENDED ACTION: State and Local government entities must work to assure that services and programs receiving public funds are available and accessible to persons with mental illness who may also be homeless. The Department will assure that DMHMR-funded services are accessible to homeless persons with serious mental illness.

RECOMMENDED ACTION: A separate and distinct process needs to be implemented to develop recommendations to meet the unique needs of children and adolescents with serious emotional disorders who are homeless. However, both the youth and adult processes must be linked in order to incorporate the individual and system needs of families and youth in late adolescence and early adulthood. The Department will participate in this process.

**THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION MUST ESTABLISH STRONG LINKAGES AND COORDINATION WITH AGENCIES AND ORGANIZATIONS REPRESENTING AND/OR INVOLVED WITH HOMELESS PERSONS.**

The needs and problems related to homelessness and persons with mental illness are broader than the scope of any one department or agency and require closely coordinated, collaborative efforts. The Department of Mental Health and Mental Retardation must continue a strong relationship with the Interagency Task Force on Homelessness and Housing Opportunities and the Maine Coalition for the Homeless on both the program and policy levels. Close linkages must be established between the private and public sectors.

The Department, in conjunction with other State and local governmental agencies, should examine the availability and accessibility of their services, programs, and benefits to homeless persons with mental illness and develop concrete, coordinated strategies and processes aimed at preventing and ameliorating homelessness. Many of the service and resource needs of homeless persons with mental illness are not mental health services but are the same as those of any person who is homeless. Basic needs, including health care, must be addressed. When asked, homeless persons--including those with specialized needs--generally identify their need for housing, food, income, and health care before, for example, psychological or other specialized services.

Without the involvement and collaboration of other State and local government agencies, including the Departments of Corrections, Human Services, and Educational and Cultural Services and the Maine State Housing Authority, as well as local public assistance and criminal justice agencies, efforts to assist homeless persons with mental illness cannot succeed.

RECOMMENDED ACTION: The Department of Mental Health and Mental Retardation will include broad representation, including the Interagency Task Force on Homelessness and Housing Opportunities and the Maine Coalition for the Homeless, in planning for mental health homelessness services. This should occur both as part of more comprehensive mental health planning activities and, specifically, in relation to discrete homelessness funding opportunities such as the federal PATH program.

RECOMMENDED ACTION: The Department of Mental Health and Mental Retardation will identify other service areas in which the needs of homeless persons with mental illness should be reflected and will provide input and coordinate with those activities. This includes, for example, such activities as the Federal homelessness educational programs, vocational programs, and Federal and State housing and shelter opportunities.

RECOMMENDED ACTION: The Department must work actively and closely with other State and local agencies to assure the development of a system of Representative Payees available and accessible to homeless persons with mental illness.

## DMHMR HOUSING ASSISTANCE, DEVELOPMENT, AND RESOURCES MUST TARGET THIS POPULATION GROUP AS A PRIORITY.

Provision for the development of a variety of safe and stable low-cost permanent housing must clearly be the first step in any homelessness strategy. Once this has been done, supportive services must also be provided, for the provision of housing alone will not prevent future homelessness. Appropriate supportive services will enable the individual or family to maintain their stability in the community.

This has been evidenced in a GAO study of the Stewart B. McKinney Homeless Transitional Housing Programs: It indicated that persons with mental illness or substance abuse disorders had the most difficulty in maintaining stable housing, but pointed out that the prospect for success improved with the provision of each additional supportive service.

Flexibility in housing provision and development as a fundamental characteristic of an effective housing policy should not be underestimated in the demand for accountability and predictability. As housing plans are developed, the Department and other agencies should be knowledgeable of and sensitive to the needs of persons who are homeless and have mental illness.

The Department should provide expertise to and encourage providers to take advantage of housing development opportunities, such as the federal Shelter + Care program.

RECOMMENDED ACTION: The Department of Mental Health and Mental Retardation will assure priority for persons with mental illness who are homeless or at imminent risk of homelessness for DMHMR-funded housing and residential services.

RECOMMENDED ACTION: The Department will stress the development of housing related services which aid in the prevention of homelessness, such as supportive residential services to assist individuals in maintaining themselves in their housing (budgeting, daily living skills, etc.), programs to enable individuals to keep their housing during periods of hospitalization, etc.

RECOMMENDED ACTION: The Department will work with other housing organizations to assure accessibility of persons with mental illness to housing and to housing services and resources such as low-income housing, Section 8's, etc.

## FLEXIBLE COMMUNITY MENTAL HEALTH SERVICES WITH OUTREACH CAPACITY SHOULD BE ENHANCED TO MEET THE IMMEDIATE AND COMPLEX NEEDS OF HOMELESS PERSONS WITH MENTAL ILLNESS.

Engaging and meeting the needs of individuals with mental illness who are also homeless requires a commitment to the development of immediate, coordinated, and flexible services. These must have the capacity to reach out to individuals wherever they are and to be consistently available. Some of these services are, therefore, heavily reliant on the availability of personnel and intensive staff time.

RECOMMENDED ACTION: Full-time mental health specialist positions should be developed and located in shelters. The possibility of shifting federal PATH funds from their current use to pilot projects in Bangor, Lewiston/Auburn, Portland, and York County should be explored by the Department of Mental Health and Mental Retardation.

Recommendations regarding supervision of these positions have varied among mental health agencies and shelters; however, there is some consensus that these mental health professionals, while clinically supervised by licensed mental health entities, could work on a daily basis within the purview of the shelter and its administration.

RECOMMENDED ACTION: A system of "circuit" mental health professionals needs to be developed for shelters and domestic violence centers to meet the needs of persons with mental illness who are homeless. These professionals could be psychiatrists, psychologists, or licensed clinical social workers.

RECOMMENDED ACTION: The Department of Mental Health and Mental Retardation should assure the availability of around-the-clock mental health crisis intervention services to shelters. Such services are not uniformly available throughout the state.

RECOMMENDED ACTION: The provision of vocational services by the Department of Mental Health and Mental Retardation and the Departments of Human Services and Labor, should incorporate the flexibility required to meet the needs of homeless persons with mental illness, including in supported employment programs.

**ADVOCACY, EDUCATION, AND TRAINING REGARDING HOMELESSNESS, MENTAL HEALTH, AND MENTAL ILLNESS MUST BE PROVIDED ON AN INDIVIDUAL, PROGRAM, AND COMMUNITY LEVEL.**

Collaboration among the various entities concerned with homelessness must be an integral part of any strategy developed. This is particularly true of the necessity for involvement at the community level. While most communities and individuals are aware of homelessness and its implications and may be sympathetic on a broad scale, this often becomes less true on an immediate or local level. Yet, this is also often where much can be done--landlords willing to rent to special populations, employers becoming willing to hire homeless persons, enactment of zoning ordinances, etc. The development of public education and advocacy on an immediate regional level, emphasizing the strengths of the community, can be influential and pivotal. An informed community is essential in this process.

In addition, the Department of Mental Health and Mental Retardation must explore and plan for the provision of specific education and training regarding both mental health and mental illness to agencies and programs serving homeless persons. Programs, such as shelters, provide services to a broad variety of individuals, most with very complex needs. For almost all, this has had to be done without specialized training and with, generally, few specialized supportive services. Such a training effort should not focus solely on homeless persons with serious mental illnesses but should encompass the broader mental health needs and aspects of the homeless population. The knowledge and experience of consumers of mental health services should be utilized in these efforts.

In order to increase their effectiveness as well as that of their organizations, training should also be provided statewide to the boards of directors of the many non-profit service agencies and organizations serving vulnerable population groups, including homeless persons. Such training should include the role and responsibilities of board members, organizational and systems theory, etc.

RECOMMENDED ACTION: The Division of Public Education within the Department of Mental Health and Mental Retardation should 1) determine the mental health and homelessness education and training needs of shelter staff and others involved with homeless persons with mental illness, mental health service staff, community members (such as landlords, employers), and boards of directors of relevant service agencies and 2) begin to develop educational and training programs to meet those needs.

**THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION WILL BEGIN TO ADDRESS TRANSPORTATION PROBLEMS THROUGH PROVISION FOR ACTIVE MENTAL HEALTH REPRESENTATION ON THE LOCAL TRANSPORTATION BOARDS.**

The Department has the opportunity, through federal transportation funding mandates, to provide for mental health representatives to sit on the local transportation advisory boards. Although mental health monies form an extremely small percentage of public transportation funds, these representatives can provide information regarding mental health needs and explore other creative and flexible options in transportation provision.

RECOMMENDED ACTION: The Department will designate mental health representatives for each of the regional transportation boards and review the annual regional plans and advocate for their responsiveness to the needs of persons with mental illness.

THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION, IN CONJUNCTION WITH THE MAINE COALITION FOR THE HOMELESS AND THE INTERAGENCY TASK FORCE ON HOMELESSNESS AND HOUSING OPPORTUNITIES, MUST EXPLORE THE OPTIONS IN CONDUCTING A SURVEY OF INDIVIDUALS, PROGRAMS, AND SYSTEMS TO ASSESS THE CHARACTERISTICS AND NEEDS OF HOMELESS INDIVIDUALS WITH MENTAL ILLNESS, AS WELL AS THEIR COMMUNITIES AND THOSE PROVIDING SERVICES TO THEM.

Effective service system development and delivery is reliant on the accurate identification of the characteristics and needs to be met. For example, services developed for areas where homeless individuals may be primarily single males, many with mental illness and/or substance abuse disorders, will differ from those developed for areas with a high number of families. Such knowledge affects the type, breadth, and range of services developed.

An ongoing count and assessment of homeless persons, identifying and assessing those with metal illness, is a costly process, requiring great resources--both financial and human. However, because of the need for accurate information, the Department should explore the possibility of this process in its examination of alternative methods. Any method used should be uniform and reliable, appropriate and able to identify mental health characteristics and needs, and address both individual and community and service system characteristics and needs. It should also address not only single adults but youth and families, as well as special subpopulation groups such as those persons who also have substance abuse problems or are involved with the criminal justice system. The cause(s) of individuals' homelessness, including the cultural and societal context, should also be determined as an aspect of analysis and strategies toward the prevention of future homelessness.

RECOMMENDED ACTION: The Department will, through its impending Individualized Supportive Planning process, identify the unmet needs of persons with mental illness related to maintaining stable housing and will incorporate these in fiscal and program planning.

RECOMMENDED ACTION: The Department will explore options which would be feasible in identifying the scope and nature of the needs of persons who are homeless and mentally ill.

# APPENDICES

## REGIONAL PRIORITIES

## PORTLAND

I. **Lack of affordable and accessible services** (especially housing, counseling, psychiatric care).

II. **Full spectrum of affordable housing from apartments to structured homes,** especially taking into account people with mental illness who are on the streets and difficult to engage.

III. **Transportation** (lack of transportation to services forces individuals to move to urban areas to access services).

IV. **Outreach/case management services.**

V. **Coordinated services for clients** (Not services coordinated for the system).

VI. **Lack of counseling.**

VII. **Medical care.**

VIII. **Monies for basic needs.**

IX. **Special needs for youth,** essentially in two major age groups: seventeen and under (underserved) and eighteen to twenty-one (fit in neither with youth nor adults).

X. **Special services for those who are dually-diagnosed.**

XI. **Payeeship.**

## PRESQUE ISLE

Resources:

I. Crisis stabilization beds (staffed).

II. Supported housing with comprehensive services.

III. State-funded position to be the representative payee for clients requiring this service.

IV. Utilization of military base housing resulting from base closing: 20% of current number allotted to Presque Isle and Caribou -- To be used for supportive apartments and SRO's which would also be supported by Section 8's.

V. Transportation.

Coordination:

I. Additional funding so that greatly increased mental health consultation and training can be provided to shelter staff.

II. Funding for housing advocate for clients and for landlords (to provide information re: persons with mental illness and mental health programs, etc.).

III. Development of an ongoing community task force to assess needs, resources, and services.

## BANGOR

I. **Crisis stabilization services:** Respite beds and full crisis program including psychiatric care, counseling, etc.. (Phone Help line cannot meet need.)

II. **Assurance of no BMHI discharges without adequate supportive services having been arranged.**

III. **More case management services.**

IV. **A. Transitional housing/shelter with supportive services, as well as adult foster care.**

**B. Affordable, adequate, and safe housing of all types with supportive services available.**

V. **Daytime activity, service, and program alternatives.** Homeless persons need activities, day programs, during the day hours. This is especially a problem on Sundays.

VI. **Single point of application, coordination of service and entitlement programs.**

VII. **Representative payeeship** (would be great help in maintaining housing in the community).

VIII. **Expanded outpatient services** (there are currently waiting lists).

## AUGUSTA

I. Additional shelter capacity for persons with mental illness.

II. A consistent base and range of services in each service area.

III. Homeless persons with mental illness to be designated a priority population group.

IV. One-stop application, referral, and coordination location within each service area.

V. Greater role for consumers in teaching agencies and programs re: nature and needs of persons with mental illness who are also homeless.

VI. Development of adequate housing and supportive services in rural areas.

VII. Focus on the needs of homeless youth with emotional disorders.

## DEFINITIONS

### CHILDREN AND ADOLESCENTS WITH SEVERE EMOTIONAL DISORDERS

The Bureau of Children with Special Needs, Department of Mental Health and Mental Retardation, following national guidelines, defines severely emotionally disturbed children as those who meet the following operational criteria:

1) Age: 20 years and under.

2) Psychiatric Diagnosis: Mental health problem diagnosable under DSM-III-R (Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised, American Psychiatric Association, 1987).

3) Duration: Long-term nature of the disability defined as one (1) year duration of disability or substantial risk of over one (1) year duration.

4) Severity of Disability: Inability to function in home, school, or community without supportive services.

5) Multi-agency Need: The level of disability requires multi-agency intervention, from two or more service systems, such as mental health, health, juvenile justice, social welfare, special education, or other community service provider.

## ADULTS WITH SEVERE AND PROLONGED MENTAL ILLNESS

The Bureau of Mental Health, Department of Mental Health and Mental Retardation, defines adults with severe and prolonged mental illness as being eighteen years and older and meeting DSM-III-R Axis I criteria for mental disorders (with the exception of mental retardation, substance abuse disorders, adjustment disorders, and V codes) and Axis V criteria indicating serious functional impairment when combined with the presence of the following characteristics:

A. General Characteristics: (One of the following must apply.)

. All persons currently receiving active discharge planning while in a state hospital or who have been discharged in the last six months.

. All persons with psychiatrically related diagnoses receiving active discharge planning from other inpatient units or residential treatment centers or who have been discharged in the last six months.

. Persons with hospitalization or residential treatment care of at least six months in the last eighteen months.

. Two or more periods of hospitalization in the last six months.

. Four or more psychiatric emergency face-to-face incidents in the last twelve months.

. Other persons with a history of hospitalization, who are currently receiving psychotropic medication(s), who have a diagnostic history of major mental illness, and/or whose functioning ability is such that community support, day treatment/rehabilitation is needed.

B. Functional Characteristics: (Signs or symptoms of mental or emotional disorder must be of sufficient severity to cause a disturbance in role performance or functional abilities as evidenced by the presence of one or more of the following characteristics.)

. The person is homeless or at risk of losing his/her current residence.

. The person is unable to work, has experienced behaviorally observable deterioration in social support or vocational performance, or is facing imminent extrusion from job or family.

. The person's ability to carry out usual roles and functions in the community is grossly impaired due to psychiatric symptoms or antisocial behaviors.

. The person has become socially isolated, has no social support system, and has lost or failed to acquire the capacity to develop such a system.

. The person is unable to support him/herself or manage his/her finances without assistance.

. The person is causing disturbances in the community because of poor judgment or antisocial, bizarre, or intrusive behavior.

. The person exhibits behaviorally observable deteriorating clinical symptoms, as determined by a qualified mental health professional, leading to hospitalization, psychiatric emergencies, difficulties with the criminal justice system, or the need for other restrictive forms of care.

. The person lacks service support systems which are adequate to restore his/her previous level of functioning in the absence of services.

C. Special Diagnostic Criteria: (Persons meeting DSM-III-R, Axis II diagnostic criteria will also be defined as persons with severe mental illness when at least one of the following psychiatric signs or symptoms is present.)

. Attempts or threats of suicide.

. Confusion, disorientation, memory loss, and lack of judgment which impair behavioral functioning.

. Hallucinations, which are active and distracting to the individual, impair behavioral functioning.

. Delusional or disorganized thoughts which impair behavioral functioning.

. Grossly bizarre behavior with severe disturbances of mood or affect.

. Severe psychomotor retardation, agitation, or hyperactivity.

. Grossly inappropriate or grossly blunted affect.

. Inability to care for self which, through failure to receive treatment, will result in severe deterioration of medical condition(s) or will create life or limb threatening condition(s).